NOTICE OF INTENT

Office of the Governor
Division of Administration
Office of Group Benefits

Employee Benefits (LAC 32:I-IX)

In accordance with the applicable provisions of R.S. 49:950, et seq., the Administrative Procedure Act, and pursuant to the authority granted by R.S. 42:801(C) and 802(B)(6), vesting the Office of Group Benefits (OGB) with the responsibility for administration of the programs of benefits authorized and provided pursuant to Chapter 12 of Title 42 of the Louisiana Revised Statutes, and granting the power to adopt and promulgate rules with respect thereto, OGB finds that it is necessary to revise and amend several provisions of Title 32 in the Louisiana Administrative Code. This action will enhance member clarification and provide for the administration, operation, and management of health care benefits effectively for the program and member. Accordingly, OGB hereby gives Notice of Intent to adopt the following Rules to become effective upon promulgation.

Title 32
EMPLOYEE BENEFITS
Part I. General Provisions

Chapter 1. General Information
§101. Organizational Description~~—Purpose of Agency~~

A. The Office of Group Benefits operates pursuant to La. R.S. 42:801 *et seq.* OGB is responsible for the general administration and management of all aspects of programs of benefits as authorized or provided for under the provisions of this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

§103. Other Authorized Plans

A. Plan Insurer and Plan Administrator. To the extent any governmental and administrative subdivisions, departments, or agencies of the executive, legislative, or judicial branches, or the governing boards and authorities of each state university, college, or public elementary and secondary school system in the state are authorized to procure private contracts of health insurance and/or operate or contract for all or a portion of the administration of a self-funded plan, such plans not directly operated by OGB shall be governed by the terms and conditions of the applicable plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

Chapter 3. ~~Entrance into the Program~~ Uniform Provisions – Participation in the Office of Group Benefits
§301. Eligibility for Participation in OGB Health Coverage and Life Insurance

A. Employees of a public entity who participate in the Louisiana State Employees Retirement System, Louisiana Teacher's Retirement System, State Police Pension and Retirement System, or the Louisiana School Employees Retirement System due to their status as an employee of such public entity are eligible to participate in OGB group benefit programs pursuant to La R.S. 42:808. No individual may participate in a program sponsored by OGB unless the school board, state agency or political subdivision through which the individual is actively employed or retired participates in OGB as a group.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 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 8:486 (September 1982), LR 17:891 (September 1991), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 40:

§303. ~~Eligibility~~ Enrollment Procedures for Participation in OGB Health Coverage and Life Insurance

A. Any state agency, school board, political subdivision, or other entity that seeks to participate in programs offered through OGB shall comply with the following:
   1. The head of the agency shall submit a written request to OGB to commence participation in its programs, together with a resolution of authorization from the board, commission, or other governing authority, if applicable.
   2. The request for participation shall be reviewed to verify the eligibility of the requesting agency.
   3. The requesting agency shall obtain an experience rating from OGB.
      a. The requesting agency shall submit claims experience under its prior plan for the 36 month period immediately prior to its application together with the required advance payment to cover the cost of the experience rating.
      b. The actuarial consultant serving OGB shall conduct the experience rating and determine the premiums due.
      c. For any state agency, school board, political subdivision, or other entity that elects to participate in the OGB health and accident programs after participation in another group health and accident insurance program, the premium rate applicable to the employees and former employees of such group shall be the greater of the premium rate 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.
      d. In the event that the initial premium is based on the loss experience of the group under the prior plan, such premium shall remain in effect for three years and then convert to the published rate for all other OGB enrollees.

B. Open enrollment is a period of time, designated by OGB, during which an eligible employee or retiree may enroll for benefits under an OGB plan. OGB will hold open enrollment for a coverage effective date of January 1 or such other date as may be determined by OGB. Transfer of coverage will only be allowed during open enrollment, unless otherwise allowed or required by OGB or state or federal law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Board of Trustees, State Employees Group Benefits Program, LR 6:199 (May 1980), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 40:

§305. Retiree Eligibility

A. For the purpose of determining eligibility to participate in OGB health coverage and life insurance, the term *retiree* shall refer only to an individual who was an enrollee immediately prior to the date of retirement and who, upon retirement, satisfied one of the following categories:
   1. Immediately received a retirement benefits from an approved state or governmental agency defined benefit plan;
   2. Was not eligible for participation in such plan or legally opted not to participate in such plan, and either:
      a. began employment prior to September 15, 1979, has 10 years of continuous state service, and has reached the age of 65;
      b. began employment after September 15, 1979, has 10 years of continuous state service, and has reached the age of 70;
      c. began employment 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 an OGB plan of benefits as an eligible dependent until he/she became eligible to receive a retirement benefit from an approved state governmental agency defined benefit plan as a former state employee; 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/her to receive a retirement allowance from the defined benefit plan of the retirement system for which the employee would have otherwise been eligible. The appropriate state governmental agency or retirement system responsible for administration of the defined contribution plan is responsible for certification of eligibility to OGB.

B. Retiree also means an individual who was a covered employee and continued the coverage through the provisions of COBRA immediately prior to the date of retirement and who, upon retirement, qualified for any of items 1, 2, or 3 above.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Board of Trustees, State Employees Group Benefits Program, LR 6:199 (May 1980), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 40:

§307. Persons to be Covered

A. Employee Coverage

1. For the purpose of determining eligibility to participate in OGB health coverage and life insurance, the term *employee* shall refer to a full-time employee as defined by a participating employer and in accordance with federal and state law.
2. Husband and Wife, Both Employees. No one may be enrolled simultaneously as an employee and as a dependent under an OGB plan, nor may a dependent be covered as a dependent of more than one employee. If a covered spouse is eligible for coverage as an employee and chooses to be covered separately at a later date, that person will be an enrollee 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, Transferring Employee. Coverage for each employee who follows the OGB procedures for enrollment and agrees to make the required payroll contributions to his/her participating employer is effective as follows:
    a. if employment begins on the first day of the month, coverage is effective on the first day of the following month (for example, if employment begins on July 1, coverage will begin on August 1);
    b. if employment begins on or after the second day of the month, coverage is effective on the first day of the second month following employment (for example, if employment begins on July 15, coverage will begin on September 1);
    c. employee coverage will not become effective unless the employee completes an enrollment form within 30 days following the date employment begins.
    d. an employee who transfers employment to another participating employer shall complete a transfer form within 30 days following the date of transfer to maintain coverage without interruption.
4. Re-Enrollment Previous Employment for Health Benefits and Life Insurance.
    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, employee and children, family) in force on the 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.
5. Members of Boards and Commissions. Except as otherwise provided by law, members of boards or commissions are not eligible for participation in an OGB plan of benefits. This section does not apply to members of school boards or members of state boards or commissions who are determined by the participating employer to be full-time employees.
6. Legislative Assistants. Legislative assistants are eligible to participate in an OGB plan if they are determined to be full-time employees by the participating employer and receive at least 80 percent of their total compensation as legislative assistants.

B. Retiree Coverage

1. Eligibility
    a. Retirees of participating employers are eligible for retiree coverage under an OGB plan.
    b. An employee retired from a participating employer may not be covered as an active employee.
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 participating employer have agreed to make and are making the required contributions (for example, if retired July 15, coverage will begin August 1).

C. Documented Dependent Coverage

1. Eligibility. A documented dependent of an eligible employee or retiree will be eligible for dependent coverage on the later of the following dates:
    a. date the employee becomes eligible;
    b. date the retiree becomes eligible; or
    c. date the covered employee or covered retiree acquires a dependent.
2. Effective Dates of Coverage – Application for coverage is required to be made within thirty (30) days of eligibility for coverage.

a. Documented Dependents of Employees. Coverage 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.

b. Documented Dependents of Retirees. Coverage for dependents of retirees who were covered immediately prior to retirement will be effective on the first day of the month following the date of 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.

D. Special Enrollments—HIPAA. Certain eligible persons for whom the option to enroll for coverage was previously declined and who would be considered overdue applicants may enroll as provided for by HIPAA under circumstances, terms, and conditions for special enrollments.

E. Health Maintenance Organization (HMO) Option. In lieu of participating in an OGB self-funded health plan, enrollees may elect coverage under an OGB offered fully insured HMO.

F. Medicare Advantage Option for Retirees (effective July 1, 1999). Retirees who are eligible to participate in an OGB sponsored Medicare Advantage plan who cancel participation in an OGB plan of benefits upon enrollment in an OGB sponsored Medicare Advantage plan may re-enroll in an OGB offered plan of benefits upon withdrawal from or termination of coverage in the Medicare Advantage plan at Medicare's open enrollment or OGB's open enrollment period.

G. 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 participation in an OGB plan of benefits upon enrollment in TFL may re-enroll in an OGB offered plan of benefits in the event that the TFL option is discontinued or its benefits are significantly reduced.

H. Eligibility requirements apply to all participants in OGB health coverage and life insurance programs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

§309. Medicare and OGB

A. When an individual is covered by an OGB plan of benefits and by Medicare, Medicare laws and regulations govern the order of benefit determination, that is, whether Medicare is the primary or secondary payer.

B. Except as provided in Subsection C (below), when an individual is covered by an OGB plan of benefits and by Medicare, and:

1. an OGB plan of benefits is the primary payer, benefits will be paid without regard to Medicare coverage;
2. Medicare is the primary payer, eligible expenses under an OGB plan of benefits will be limited to the amount allowed by Medicare, less the amount paid or payable by Medicare. All provisions of an OGB plan of benefits, including all provisions related to deductibles, co-insurance, limitations, exceptions, and exclusions will be applied.

C. The following applies to retirees and their covered spouses who attain or have attained the age of 65 on or after July 1, 2005, and who have no other group health coverage through present (active) employment:

1. A retiree or spouse of a retiree who attains or has attained age 65 when either has sufficient earnings credits to be eligible for Medicare, shall enroll in Medicare Part A and Medicare Part B in order to receive benefits under an OGB plan except as specifically provided in Paragraph 2, below.
2. If such retiree or spouse of a retiree is not enrolled in Medicare Part A and Medicare Part B, no benefits will be paid or payable under an OGB plan of benefits except benefits payable as secondary to the part of Medicare in which the individual is enrolled.

D. A retiree and spouse of a retiree who do not have sufficient earnings credits to be eligible for Medicare shall provide written verification from the Social Security Administration or its successor.

E. Medicare Coordination of Benefits (Retiree 100)—Upon enrollment and payment of the additional monthly premium, an enrollee and dependents who are covered under Medicare Parts A and B (both) may choose to have full coordination of benefits with Medicare. Enrollment shall be made within 30 days of eligibility for Medicare, within 30 days of retirement if already eligible for Medicare, or at open enrollment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

§ 311. Reinstatement to Position Following Civil Service Appeal

A. Self-funded Plan Participants. When coverage of a terminated employee who was enrolled in an OGB self-funded plan is reinstated by reason of a civil service appeal, coverage will be reinstated to the same level in the OGB plan of benefits retroactive to the date coverage terminated. The employee and participating 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/her position. The OGB plan is responsible for the payment of all eligible benefits for charges incurred during this period. All claims for expenses incurred during this period shall be filed with the OGB plan within 60 days following the date of the final order of reinstatement.

B. Fully Insured HMO Participants. When coverage of a terminated employee who was enrolled in a fully insured HMO is reinstated by reason of a civil service appeal, coverage will be reinstated in the fully insured 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 fully insured HMO was not effective.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

§313. Enrollee Coverage Termination

A. Subject to continuation of coverage and COBRA rules, all benefits of an enrollee will terminate under plans offered by OGB on the earliest of the following dates:

1. date OGB terminates;
2. date the group or agency employing the enrollee terminates or withdraws from OGB;
3. date contribution is due if the group or agency fails to pay the required contribution for the enrollee;
4. date contribution is due if the enrollee fails to make any contribution which is required for the continuation of coverage;
5. last day of the month of the enrollee's death; or
6. last day of the month in which the enrollee is eligible for OGB plan coverage.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

§315. Dependent Coverage Termination

A. Subject to continuation of coverage and COBRA rules, dependent coverage will terminate under any OGB plan of benefits on the earliest of the following dates:

1. last day of the month the enrollee is covered;
2. last day of the month in which the dependent, as defined by OGB, is an eligible dependent of the enrollee;
3. for grandchildren for whom the enrollee does not have legal custody or has not adopted, on the date the child's parent loses eligibility under any OGB plan or the grandchild no longer meets the definition of a child; or
4. upon discontinuance of all dependent coverage under OGB plans.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

§317. Change of Classification

A. Adding or Deleting Dependents. When a dependent is added to or deleted from the enrollee's coverage due to a qualifying event, under applicable state or federal law, active enrollees shall notify their HR liaison and retired enrollees shall notify OGB. Notice shall be provided within 30 days of the addition or deletion.

B. Change in Coverage

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

C. Notification of Change. It is the enrollee's responsibility to provide notice of any change in classification of coverage that affects the enrollee's contribution amount.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

§319. Continued Coverage

A. Leave of Absence. If an enrollee is allowed an approved leave of absence by his/her participating employer, the enrollee may retain the coverage for up to one year if the premium is paid. Failure to pay the premium will result in cancellation of coverage. The enrollee and/or the participating employer shall notify OGB within 30 days of the effective date of the leave of absence.

1. Leave of Absence without Pay, Employer Contributions to Premiums
    a. An enrollee who is granted leave of absence without pay due to a service related injury may continue coverage and the participating employer shall continue to pay its portion of health plan premiums for up to 12 months.
    b. An enrollee who suffers a service related injury that meets the definition of a total and permanent disability under the workers' compensation laws of Louisiana may continue coverage and the participating employer shall continue to pay its portion of the premiums until the enrollee becomes gainfully employed or is placed on state disability retirement.
    c. An enrollee who is granted leave of absence without pay in accordance with the federal Family and Medical Leave Act (F.M.L.A.) may continue coverage during the time of such leave and the participating employer shall continue to pay its portion of premiums if the enrollee continues his/her coverage.
2. Leave of Absence without Pay; No Employer Contributions to Premiums. An enrollee granted leave of absence without pay for reasons other than those stated in Paragraph A(1), may continue to participate in an OGB plan for a period up to 12 months upon the enrollee's payment of the full premiums due.

B. Disability - Enrollees who have been granted a waiver of premium for basic or supplemental life insurance prior to July 1, 1984, may continue OGB plan coverage for the duration of the waiver if the enrollee pays the total contribution to the participating employer. Disability waivers were discontinued effective July 1, 1984.

C. Surviving Dependents/Spouse
1. Benefits under an OGB plan of benefits for covered dependents of a deceased enrollee will terminate on the last day of the month in which the enrollee's death occurred unless the surviving covered dependents elect to continue coverage.
    a. The surviving legal spouse of an enrollee may continue coverage unless or until the surviving spouse is or becomes eligible for coverage in a group health plan other than Medicare.
    b. The surviving dependent child of an enrollee may continue coverage unless or until such dependent child is or becomes eligible for coverage under a group health plan other than Medicare or until attainment of the termination age for children, whichever occurs first.
    c. Surviving dependents will be entitled to receive the same participating employer premium contributions as enrollees, subject to the provisions of Louisiana Revised Statutes, Title 42, Section 851 and rules promulgated pursuant thereto by OGB.
    d. Coverage provided by the Civilian Health and Medical Program for the Uniformed Service (CHAMPUS/TRICARE) or successor program will not be sufficient to terminate the coverage of an otherwise eligible surviving legal spouse or dependent child.
2. A surviving spouse or dependent child cannot add new dependents to continued coverage other than a child of the deceased enrollee born after the enrollee's death.
3. Participating Employer/Dependent Responsibilities
    a. To continue coverage, it is the responsibility of the participating employer and surviving covered dependent to notify OGB within 60 days of the death of the enrollee.
    b. OGB will notify the surviving dependents of their right to continue coverage.
    c. Application for continued coverage shall be made in writing to OGB within 60 days of receipt of notification. Premiums for continued coverage shall be paid within 45 days of the coverage application date for the coverage to be effective on the date coverage would have otherwise terminated.
    d. Coverage for the surviving spouse under this section will continue until the earliest of the following:
        i. failure to pay the applicable premium timely; or
        ii. eligibility of the surviving spouse 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 timely;
        ii. eligibility of the surviving dependent child for coverage under any group health plan other than Medicare; or
        iii. the attainment of the termination age for children.
4. The provisions of paragraphs 1 through 3 of this subsection are applicable to surviving dependents who, on or after July 1, 1999, elect to continue coverage following the death of an enrollee. Continued coverage for surviving dependents who made such election before July 1, 1999, shall be governed by the rules in effect at the time.

D. Over-Age Dependents. If a dependent child is incapable of self-sustaining employment by reason of mental or physical incapacity and became incapable prior to attainment of age 26, the coverage for the dependent child may be continued for the duration of incapacity.
   1. Prior to such dependent child's attainment of age 26, an application for continued coverage is required to be submitted to OGB together with current medical information from the dependent child's attending physician to establish eligibility for continued coverage.
   2. OGB may require additional medical documentation regarding the dependent child's incapacity upon receipt of the application for continued coverage and as often as it may deem necessary thereafter.
   3. The incapacity determination shall be a medical determination subject to the appeal procedures of the enrollee's plan of benefits.

E. Military Service. Members of the National Guard or of the United States military reserves who are called to active military duty and who are OGB enrollees or covered dependents will have access to continued coverage under OGB's health and life plans of benefits.
   1. Health Plan Participation. When called to active military duty, enrollees and covered dependents may:
      a. continue participation in any OGB self-funded plan during the period of active military service and the participating employer may continue to pay its portion of premiums; or
      b. cancel participation in any OGB self-funded plan during the period of active military service and apply for reinstatement of OGB coverage within 30 days of:
         i. the date of the enrollee's reemployment with a participating employer;
         ii. the dependent's date of discharge from active military duty; or
         iii. the date of termination of extended health coverage provided as a benefit of active military duty, such as TRICARE Reserve Select.
   2. Plan participants who elect this option and timely apply for reinstatement of OGB coverage will not experience any adverse consequences with respect to the participation schedule set forth in R.S. 42:851E and the corresponding Rules promulgated by OGB.
   3. Life Insurance. When called to active military duty, enrollees with OGB life insurance coverage may:
      a. continue participation in OGB life insurance during the period of active military service, but the accidental death and dismemberment coverage will not be in effect during the period of active military duty; or
      b. cancel participation in OGB life insurance during the period of active military service and the enrollee may apply for reinstatement of OGB life insurance within 30 days of the date of the enrollee's reemployment with a participating employer; enrollees who elect this option and timely apply for reinstatement of OGB life insurance will not be required to provide evidence of insurability.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

§321. COBRA

A. Employees
   1. Coverage under OGB for an enrollee will terminate on the last day of the calendar month during which employment is terminated (voluntarily or involuntarily) or significantly reduced, the enrollee no longer meets the definition of an employee, or coverage under a leave of absence has expired, unless the enrollee elects to continue coverage at the enrollee's own expense. Employees terminated for gross misconduct are not eligible for COBRA coverage.
   2. It is the responsibility of the participating employer to notify OGB within 30 days of the date coverage would have terminated because of any of the foregoing events, and OGB will notify the enrollee within 14 days of his/her right to continue coverage.
   3. Application for continued coverage shall be made in writing to OGB within 60 days of the date of the election notification and premium payment shall be made within 45 days of the date the employee elects continued coverage, for coverage retroactive to the date coverage would have otherwise terminated. After the first payment, monthly payments for COBRA coverage are due on the first day of the month for that month's coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.
   4. Coverage under this section will continue until the earliest of the following:
      a. failure to pay the applicable premium timely;
      b. 18 months from the date coverage would have otherwise terminated;
      c. entitlement to Medicare;
      d. date coverage begins under a group health plan; or

e. the employer ceases to provide any group health plan coverage for its employees.

5. If employment for a covered employee is terminated (voluntarily or involuntarily) or significantly reduced, the enrollee 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 dependents may elect to continue coverage at his/her/their own expense. The elected coverage will be subject to the above-stated notification and termination provisions.

B. Surviving Dependents

1. Coverage under an OGB plan for covered surviving dependents will terminate on the last day of the month in which the enrollee's death occurs, unless the surviving covered dependents elect to continue coverage at their own expense.
2. It is the responsibility of the participating employer or surviving covered dependents to notify OGB within 30 days of the death of the enrollee. OGB will notify the surviving dependents of their right to continue coverage. Application for continued coverage shall be made in writing to OGB within 60 days of the date of the election notification.
3. Premium payment shall be made within 45 days of the date the continued coverage was elected, retroactive to the date coverage would have terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.
4. Coverage for the surviving dependents under this section will continue until the earliest of the following:
   a. failure to pay the applicable premium timely;
   b. 36 months beyond the date coverage would have otherwise terminated;
   c. entitlement to Medicare;
   d. date coverage begins under a group health plan; or
   e. the employer ceases to provide any group health plan coverage for its employees.

C. Divorced Spouse

1. Coverage under OGB for an enrollee's spouse will terminate on the last day of the month during which dissolution of the marriage occurs by virtue of a legal decree of divorce from the enrollree, unless the covered divorced spouse elects to continue coverage at his/her own expense.
2. It is the responsibility of the divorced spouse to notify OGB within 60 days from the date of divorce and OGB will notify the divorced spouse within 14 days of his/her right to continue coverage. Application for continued coverage shall be made in writing to OGB within 60 days of the election notification.
3. Premium payment shall be made within 45 days of the date continued coverage is elected, for coverage retroactive to the date coverage would have otherwise terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.
4. Coverage for the divorced spouse under this Section will continue until the earliest of the following:
   a. failure to pay the applicable premium timely;
   b. 36 months beyond the date coverage would have otherwise terminated;
   c. entitlement to Medicare;
   d. date coverage begins under a group health plan; or
   e. the employer ceases to provide any group health plan coverage for its employees.

D. Dependent Children

1. Coverage under an OGB plan for a covered dependent child of an enrollee 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/her own expense.
2. It is the responsibility of the dependent to notify OGB within 60 days of the date coverage would have terminated and OGB will notify the dependent within 14 days of his/her right to continue coverage. Application for continued coverage shall be made in writing to OGB within 60 days of receipt of the election notification.
3. Premium payment shall be made within 45 days of the date the continued coverage is elected, for coverage retroactive to the date coverage would have otherwise terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.

4. Coverage for children under this section will continue until the earliest of the following:
   a. failure to pay the applicable premium timely;
   b. 36 months beyond the date coverage would have otherwise terminated;
   c. entitlement to Medicare;
   d. date coverage begins under a group health plan; or
   e. the employer ceases to provide any group health plan coverage for its employees.

E. Dependents of COBRA Participants

1. If a covered terminated employee has elected to continue coverage for him/herself and covered dependents, and the enrollee dies, divorces his/her spouse, or the covered dependent child no longer meets the definition of an eligible dependent during the COBRA coverage period, then the dependents may elect to continue COBRA coverage. Coverage will not be continued beyond 36 months from the employee terminated.
2. It is the responsibility of the spouse and/or the dependent child to notify OGB within 60 days of the date COBRA coverage would have terminated.
3. Monthly payments for each month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.
4. Coverage for children under this section will continue until the earliest of the following:
   a. failure to pay the applicable premium timely;
   b. 36 months beyond the date coverage would have otherwise terminated;
   c. entitlement to Medicare;
   d. date coverage begins under a group health plan; or
   e. the employer ceases to provide any group health plan coverage for its employees.

F. Disability COBRA

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

f. 30 days after the month in which the Social Security Administration determines that the plan participant is no longer disabled. (The plan participant shall report the determination to OGB within 30 days after the date of issuance by the Social Security Administration.) In the case of a person who is ineligible for Social Security disability benefits due to insufficient "quarters" of employment, 30 days after the month in which OGB determines that the plan participant is no longer disabled.

G. Medicare COBRA

1. If an enrollee becomes entitled to Medicare less than 18 months before the date the enrollee's eligibility for benefits under OGB terminates, the period of continued coverage available for the enrollee's covered dependents will continue until the earliest of the following:
   a. failure to pay the applicable premium timely;
   b. 36 months from the date of the enrollee's Medicare entitlement;
   c. entitlement to Medicare;
   d. date coverage begins under a group health plan; or
   e. the employer ceases to provide any group health plan coverage for its employees.
2. Monthly payments for each month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.

H. Miscellaneous Provisions.

1. During the COBRA coverage period, benefits will be identical to those provided to others enrolled in an OGB plan under its standard eligibility provisions for enrollees.
2. In the event OGB contracts for COBRA administration services, OGB may direct each plan participant eligible for COBRA coverage to follow the directions provided by OGB's COBRA administrator.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

§323. Employer Responsibility

A. It is the responsibility of the participating employer to submit enrollment and coverage changes using OGB's electronic enrollment system and to review and certify all other necessary documentation to OGB on behalf of its employees. Employees of a participating employer will not, by virtue of furnishing any documentation to OGB be considered agents of OGB, and no representation made by any participating employer at any time will change the provisions of an OGB plan of benefits.

B. A participating employer shall immediately inform OGB when a retiree with OGB coverage returns to full-time employment. The enrollee shall be placed in the re-employed retiree category for premium calculation. The re-employed retiree premium classification applies to retirees with and without Medicare. The premium rates applicable to the re-employed retiree premium classification shall be identical to the premium rates applicable to the classification for retirees without Medicare.

C. A participating employer that receives a Medicare secondary payer (MSP) collection notice or demand letter shall deliver the MSP notice to OGB within 15 days of receipt. If timely forwarded, OGB will assume responsibility for medical benefits, interest, fines and penalties due to Medicare for a plan participant. If not timely forwarded, OGB will assume responsibility only for covered plan benefits due to Medicare for a plan participant. The participating employer will be responsible for interest, fines, and penalties due.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

Chapter 5. ~~School Systems~~ Uniform Provisions – Plan Administration

§501. Claims

A. To obtain the highest level of benefits available, the plan participant should always verify that a provider is a current network provider in the enrollee's plan of benefits before the service is rendered.

B. For OGB plan of benefits reimbursements, a claim shall include:

1. enrollee'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 that are valid and current for the date of service;
6. date and place of service;
7. charges;

8. enrollee's plan of benefits identification number;
9. provider tax identification number;
10. Medicare explanation of benefits, if applicable.

C. OGB or its agent may require additional documentation in order to determine the extent of coverage or the appropriate reimbursement. Failure to furnish information within the time period allowed by the respective OGB plan of benefits may constitute a reason for the denial of benefits.

D. A claim for benefits, under any self-funded plan of benefits offered by OGB shall be received by the enrollee's plan of benefits within one year from the date on which the medical expenses were incurred. The receipt date for electronically filed claims is the date on which the enrollee's plan of benefits receives the claim, not the date on which the claim is submitted to a clearinghouse or to the provider's practice management system.

E. Requests for review of payment or corrected bills shall be submitted within 12 months of receipt date of the original claim. Requests for review of payment or corrected bills received after that time will not be considered

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 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), repealed by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 40:

§503. Right to Receive and Release Information

A. To the extent permitted by federal or state law, OGB or its contractors may release to or obtain from any company, organization, or person, any information regarding any person which OGB or its contractors deem necessary to carry out the provisions of any OGB plan, or to determine how, or if, they apply. Any claimant under any OGB plan shall furnish OGB or its contractors with any information necessary to implement this provision. OGB or its contractors shall retain information for the minimum period of time required by law. After such time, information may no longer be available.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 9:342 (May 1983), repealed by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 40:

§505. Automated Claims Adjusting

A. Any OGB plan of benefits may utilize commercially licensed software that applies all claims against its medical logic program to identify improperly billed charges and charges for which an OGB plan of benefits 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 participant for the differential on the denial amount, in whole or in part.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 9:342 (May 1983), repealed by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 40:

§507. Legal Limitations and Statement of Contractual Agreement

A. A plan participant's rights and benefits under any OGB plan of benefits are personal to him/her.

B. The OGB self-funded plan, as amended, including the schedule of benefits, together with the application for coverage and any related documents executed by or on behalf of the enrollee, constitute the entire agreement between the parties.

C. In the event of any conflict between the written provisions of the OGB plan or any OGB plan of benefits with any information provided by OGB or its contractors or rules or regulations promulgated by OGB, the written provisions of the OGB plan or plan of benefits shall supersede and control.

D. A plan participant shall exhaust the administrative claims review procedure before filing a suit for benefits. No legal action shall be brought to recover benefits under an OGB plan or plan of benefits 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 a final administrative decision, whichever is later, unless otherwise provided in the terms of the participant's plan. A decision is not final until all levels of the administrative appeals process are exhausted.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

§509. Benefit Payments to Other Group Health Plans

A. When payments that should have been made under an OGB plan of benefits, have been made by another group health plan, OGB may pay to the other plan the sum proper to satisfy the terms of the enrollee's OGB plan benefits.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

§511. Recovery of Overpayments

A. If an overpayment occurs, OGB retains the right to recover the overpayment. The plan participant, institution, or provider receiving the overpayment must return the overpayment. At OGB'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 for coverage or a claim for benefits, the defendant shall be responsible for attorney fees of 25 percent of the overpayment or $1,000, whichever is greater. The defendant shall also be responsible for court costs and legal interest from the date of judicial demand until paid.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

§513. Subrogation and Reimbursement

A. Upon payment of any eligible benefits covered under an OGB plan of benefits, OGB shall succeed and be subrogated to all rights of recovery of the plan participant or his/her heirs or assigns for whose benefit payment is made and he/she shall execute and deliver instruments and papers and do whatever is necessary to secure such rights and shall do nothing to prejudice such rights.

B. OGB has an automatic lien against and shall be entitled, to the extent of any payment made to a plan participant, to 100% of the proceeds of any settlement or judgment that may result from the exercise of any rights of recovery of a plan participant against any person or entity legally responsible for the disease, illness, accident, or injury for which said payment was made.

C. To this end, plan participants agree to immediately notify OGB or its agent of any action taken to attempt to collect any sums against any person or entity responsible for the disease, illness, accident, or injury.

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

E. Under these subrogation and reimbursement rights, OGB has a right of first recovery to the extent of any judgment, settlement, or any payment made to the plan participant, his/her heirs or assigns. These rights apply whether such recovery is designated as payment for pain and suffering, medical benefits, or other specified damages, even if he/she is not made whole (i.e., fully compensated for his/her injuries).

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

§515. Program Responsibility

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

§517. Amendments to or Termination of the OGB Plan

A. OGB has the statutory responsibility of providing life, health, and other benefit programs to the extent that funds are available. OGB reserves the right to terminate, amend, or make adjustment to the eligibility and benefit provisions of any OGB plan or any plan benefits from time to time as necessary to prudently discharge its duties. Nothing contained herein shall be construed to guarantee or vest benefits for any plan participant.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

§519. Eligible Expenses

A. Eligible expenses are the charges incurred for the services, drugs, supplies, and devices covered by the applicable plan of benefits, when performed, prescribed, or ordered by a physician or other authorized provider

under a plan of benefits and medically necessary for the treatment of a plan participant. All charges are subject to applicable deductibles, co-payments, and/or co-insurance amounts, fee schedule limitations, schedule of benefits, limitations, and exclusions, and other provisions of the plan of benefits. A charge is incurred on the date that the service, drug, supply, or device is performed or furnished.

B. Eligible expenses may be different depending on the plan of benefits selected by the enrollee. Eligible expenses for each plan of benefits are included in the respective plan document. OGB will make available a copy of its plan documents to its enrollees at the beginning of the plan year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

§521. 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. 42:801(C) and 802(B)(1).

Chapter 7. Election Rules and Regulations

§701. ~~Composition of Board of Trustees~~ Group Benefits Policy and Planning Board

Reserved

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:200 (May 1980), repealed by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 40:

§703. Candidate Eligibility

A. A candidate for a position on the ~~board of trustees~~ Group Benefits Policy and Planning Board (OGB Board) must be a participant in ~~the program~~ an OGB plan of benefits as of the specified election date.

B. If elected, the board member must continue to be a participant in program an OGB plan of benefits during his/her tenure on the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:200 (May 1980), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 40:

§705. Petitions for Candidacy

A. To become a candidate, a person must be nominated by petition of 25 or more participants in the State Employees Group Benefits Program OGB plan enrollees from the ranks of the employees agency he/she they will represent.

B. ~~The petitioning participants'~~ Each enrollee's signature must be accompanied by ~~their~~ his/her Social Security number.

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 agency he/she will represent ~~ranks of employees they will be representing~~, and an active plan member on the specified ~~membership~~ election date.

D. Petitions for candidacy must be ~~in the office of~~ received by ~~the State Employees Group Benefits Program~~ OGB on or before the date indicated on the election materials.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:200 (May 1980), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 40:

§707. Ballot Preparation and Distribution

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

B. All candidates will 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~~ Ballots and information sheets on candidates will be ~~distributed to each assigned group benefits invoice coordinator (agency contact) for distribution~~ provided to eligible voters by OGB or its election vendor.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:200 (May 1980), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 40:

§709. Balloting Procedure

A. ~~All participants enrolled in the Group Benefits Program~~ All enrollees in an OGB plan of Benefits on the specified ~~membership~~ election 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.~~B.Each eligible ~~plan member~~ enrollee may cast only one vote for any candidate listed on the ballot.

~~D.~~C.~~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.~~

Each eligible enrollee must follow the voting directions provided by OGB. In the event OGB contracts with an election vendor for a particular election, each eligible enrollee must follow the voting directions provided by OGB's election vendor for his/her vote to be counted.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:200 (May 1980), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 40:

§711. Ballot Counting

A. The ballots will be counted by the ballot counting committee.

~~B.~~ 1.The ballot counting committee shall be composed of OGB employees ~~of the state employees group benefits program,~~ appointed by the ~~executive director~~ chief executive officer.

~~C.~~ 2. The ballot counting committee and all candidates will be notified at the time and date fixed for tallying the ballots.

~~D.~~ 3. The ballot counting committee will be responsible for the opening, preparation, and counting of the ballots.

~~E.~~4. All candidates or his/her representative may observe the ballot counting procedure.

B. In the event OGB contracts with an election vendor for a particular election, the election vendor will handle counting and verification of the ballots.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:200 (May 1980), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 40:

§713. Election Results

A. The chief executive ~~director~~ officer will certify the election results to the ~~board of trustees~~ OGB Board.

~~B.~~C.The ~~board of trustees~~ OGB Board will announce the election results at the first regularly scheduled board meeting following the election.

~~C.~~B.The ~~board of trustees~~ chief executive officer will notify the successful candidates of their election.

D. The ~~board of trustees~~ OGB Board will certify the election results to the Secretary of State.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:200 (May 1980), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 40:

§715. Uniform Election Dates

A. For each election date, the following dates will apply:

1. On the ~~First~~ first Monday in March, ~~Group Benefits~~ OGB submits nomination sheets to each agency~~'s~~ benefits ~~designated invoice~~ coordinator.

~~B.~~2. The ~~First~~ first Monday in April is the ~~Nomination~~ nomination cutoff date. Nominees must be certified by their agency before nominations can be accepted by ~~Group Benefits~~ OGB.

~~C.~~3. On the ~~Second~~ second Monday in April, ~~Drawing~~ OGB will hold the drawing at ~~State Employees Group Benefit Program Office at 2648 Wooddale Boulevard, Baton Rouge,~~ its principal office to determine the position each candidate will have on the ballot. All candidates are invited to attend or send a representative.

~~D.~~4.Prior to the first Monday in May, ballots will be sent to the proper authority for distribution.

~~E.~~5.The ~~Second~~ second Monday in June, ~~COB. Deadlines~~ is the deadline for OGB to ~~receiving~~ receive ballots. ~~in State Employees Group Benefits Program Office.~~

~~F.~~6. By the ~~Third~~ third Monday in June, ~~All~~ all ballots shall be counted.

~~G. Election results promulgated at next board of trustees meeting following the counting of ballots.~~

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 7:122 (March 1981), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 40:

§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*—persons 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*—persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent or the Pacific Islands.~~

~~*Black*—not of *Hispanic* origin. Persons having origin in any of the black racial groups of Africa.~~

~~*Hispanic*—persons 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, LA 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. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 7:49 (February 1981), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 40:

~~§719.~~ §717. Petition Form

A. Nominating Petition

Nominations will be submitted on a form substantially in compliance with the following:

We the undersigned ~~state employees and participants in the State Employees Group Benefits Program,~~ OGB enrollees hereby nominate _____ for membership on the ~~Board of Trustees of the State Employees Group Benefits Program~~ Office of Group Benefits Policy and Planning Board.

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~~ OGB enrollees as of the specified election date.

_____

Agency Chief Personnel Officer

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 7:50 (February 1981), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 40:

Chapter 11. Contributions

§1101. Collection and Deposit of Contributions

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

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

C. Payments received by ~~the~~ OGB ~~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~~ OGB plan of benefits offered coverage ~~provided under the board's authority~~ shall be deposited directly with ~~the~~ OGB ~~board~~. ~~The~~ OGB ~~board~~ shall pay all monies due for such benefits as they become due and payable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 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 26:2788 (December 2000), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 40:

§1103. Adjustments for Terminated Employees

A. Credit adjustments for premiums paid on behalf of ~~employees and dependents of such employees~~ enrollees whose coverage under ~~the State Employees Group Benefits Program~~ an OGB plan of benefits 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. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 26:2788 (December 2000), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 40:

§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~~ OGB ~~board~~ within 30 days after receipt of the monthly invoice premium statement, then~~:~~

~~1.~~ at the request of ~~the~~ OGB ~~board~~, the state treasurer shall withhold from state funds due the participating employer the full amount of the delinquent employer and employee contributions. The state treasurer shall ~~and~~ remit this amount directly to ~~the~~ OGB ~~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. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 26:2788 (December 2000), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 40:

§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 plan of benefits ~~self- insured health plan, as defined herein,~~ before January 1, 2002, but subsequently enrolls in an OGB plan of benefits, ~~self-insured health plan~~, or any person who commences employment with an OGB participating employer on or after January 1, 2002, the state contribution of the premium for participation in an OGB plan of benefits ~~self-insured health~~ plan upon retirement shall be:

1. 19 percent for those persons with less than 10 years of participation in an OGB plan of benefits ~~self-insured health plan~~ before retirement;

2. 38 percent for those persons with 10 years of participation but less than 15 years of participation in an OGB plan of benefits ~~self- insured health plan~~ before retirement;

3. 56 percent for those persons with 15 years of participation but less than 20 years of participation in an OGB plan of benefits ~~self- insured health plan~~ before retirement;

4. 75 percent for those persons with 20 or more years of participation in an OGB plan of benefits ~~self-insured 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 plan of benefits ~~self- insured 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 plan of benefits ~~self- insured 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 plan of benefits ~~self-insured health plan~~ before July 1, 2002, and continuous coverage is maintained until the employee's death.

~~D. The term "OGB self-insured 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 the self-insured plans such as the PPO and the EPO, and fully insured HMO plans offered as alternative options.~~

~~E~~D. 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 plan of benefits ~~self-insured health plan~~ 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. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 28:306 (February 2002), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 40:

§1109. Retirees with Medicare Parts A and B

A. ~~For all employees~~ Employees who retire on or after July 1, 1997, shall receive a ~~the~~ reduced premium rate ~~for retirees with Medicare will be applied only with respect to those persons who are~~ when enrolled ~~for~~ in Medicare Parts A and B.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 28:306 (February 2002), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 40:

Part III. ~~Preferred Provider (PPO)~~ Primary Plan of Benefits

Chapter 1. ~~Eligibility~~ Operation of Primary Plan

§101. HMO Plan Structure - Magnolia Local Plus

A. Pursuant to La R.S. 42:851H(1), OGB has authority to designate a primary plan. The Magnolia Local Plus Plan is designated hereby as the OGB primary plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

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), LR 29:341, 342 (March 2003), LR 32:1883 (October 2006). repealed LR 40:

§103. ~~Continued Coverage~~ Deductibles

Deductible Amount Per Benefit Period:

Individual:	
Network Providers:	$500.00
Non-Network Providers:	No Coverage
Family Unit Maximum:	
Network Providers:	$1,500.00
Non-Network Providers:	No Coverage

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1827 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 30:1191 (June 2004), LR 32:1884 (October 2006), LR 36:2285 (October 2010), repealed LR 40:

§105. ~~COBRA~~ Out of Pocket Maximums

Out-of-Pocket Maximum Per Benefit Period (Includes All Eligible Copayments, Coinsurance Amounts and Deductibles):

Individual:
Network Providers: $3,000.00
Non-Network Providers: No Coverage

Family:
Network Providers: $9,000.00
Non-Network Providers: No Coverage

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1828 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1885 (October 2006), repealed LR 40:

§107. ~~Change of Classification~~ Schedule of Benefits

COPAYMENTS and COINSURANCE

	NETWORK PROVIDERS		**NON-NETWORK PROVIDERS**
Physician Office Visits including surgery performed in an office setting: • General Practice • Family Practice • Internal Medicine • OB/GYN • Pediatrics	$25 Copayment per Visit		No Coverage
Allied Health/Other Professional Visits: • Chiropractors • Federally Funded Qualified Rural Health Clinics • Nurse Practitioners • Retail Health Clinics • Physician Assistants	$25 Copayment per Visit		No Coverage
Specialist Office Visits including surgery performed in an office setting: • Physician • Podiatrist • Optometrist • Midwife • Audiologist • Registered Dietician • Sleep Disorder Clinic	$50 Copayment per Visit		No Coverage

Ambulance Services – Ground (*for Emergency Medical Transportation only*)	$50 Copayment		No Coverage
Ambulance Services – Air (*for Emergency Medical Transportation only*)	$250 Copayment		No Coverage
Ambulatory Surgical Center and Outpatient Surgical Facility	$100 Copayment[2]		No Coverage
Autism Spectrum Disorders (ASD)	$25/$50 Copayment[3] per Visit depending on Provider		No Coverage
Birth Control Devices – Insertion and Removal (*as listed in the Preventive and Wellness Article in the Benefit Plan*)	100% - 0%		No Coverage
Cardiac Rehabilitation (*limit of 48 visits per Plan Year*)	$25/$50 Copayment per day depending on Provider $50 Copayment – Outpatient Facility[2]		No Coverage
Chemotherapy/Radiation Therapy (*Authorization not required when performed in Physician's office*)	Office – $25 Copayment per Visit Outpatient Facility 100% - 0%[1,2]		No Coverage
Diabetes Treatment	80% - 20%[1]		No Coverage
Diabetic/Nutritional Counseling - Clinics and Outpatient Facilities	$25 Copayment		No Coverage
Dialysis	100% - 0%[1,2]		No Coverage
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	80% - 20%[1,2] of first $5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of $5,000 per Plan Year		No Coverage
Emergency Room (*Facility Charge*)	$150 Copayment; Waived if Admitted		
Emergency Medical Services (*Non-Facility Charges*)	100% - 0%[1]		100% - 0%[1]
Eyeglass Frames and One Pair of Eyeglass Lenses or One Pair of Contact Lenses (*purchased within six months following cataract surgery*)	Eyeglass Frames – Limited to a Maximum Benefit of $50[1,3]		No Coverage
Flu shots and H1N1 vaccines (*administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair*)	100% - 0%		No Coverage

Hearing Aids (*Hearing Aids are not covered for individuals age eighteen (18) and older.*)	80% - 20%[1,3]		No Coverage
Hearing Impaired Interpreter expense	100% - 0%[1]		No Coverage
High-Tech Imaging – Outpatient • CT Scans • MRA/MRI • Nuclear Cardiology • PET/SPECT Scans	$50 Copayment[2]		No Coverage
Home Health Care (*limit of 60 Visits per Plan Year*)	100% - 0%[1,2]		No Coverage
Hospice Care (*limit of 180 Days per Plan Year*)	100% - 0%[1,2]		No Coverage
Injections Received in a Physician's Office (*allergy and allergy serum*)	100% - 0%[1]		No Coverage
Inpatient Hospital Admission, All Inpatient Hospital Services Included	$100 Copayment per day[2], maximum of $300 per Admission		No Coverage
Inpatient and Outpatient Professional Services for Which a Copayment Is Not Applicable	100% - 0%[1]		No Coverage
Mastectomy Bras – Ortho-Mammary Surgical (*limited to two (2) per Plan Year*)	80% - 20%[1,2] of first $5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of $5,000 per Plan Year		No Coverage
Mental Health/Substance Abuse – Inpatient Treatment	$100 Copayment per day[2], maximum of $300 per Admission		No Coverage
Mental Health/Substance Abuse – Outpatient Treatment	$25 Copayment per Visit		No Coverage
Newborn – Sick, Services excluding Facility	100% - 0%[1]		No Coverage
Newborn – Sick, Facility	$100 Copayment per day[2], maximum of $300 per Admission		No Coverage
Oral Surgery (*Authorization not required when performed in Physician's office*)	100% - 0%[1,2]		No Coverage
Pregnancy Care – Physician Services	$90 Copayment per pregnancy		No Coverage

Preventive Care – Services include screening to detect illness or health risks during a Physician office visit. The Covered Services are based on prevailing medical standards and may vary according to age and family history. (*For a complete list of benefits, refer to the Preventive and Wellness Article in the Benefit Plan.*)	100% - 0%[3]		No Coverage
Rehabilitation Services – Outpatient: • Physical/Occupational (*Limited to 50 Visits Combined PT/OT per Plan Year. Authorization required for visits over the Combined limit of 50.*) • Speech • Cognitive • Hearing Therapy	$25 Copayment per Visit		No Coverage
Skilled Nursing Facility – Network (*limit of 90 days per Plan Year*)	$100 Copayment per day[2], maximum of $300 per Admission		No Coverage
Sonograms and Ultrasounds (*Outpatient*)	$50 Copayment		No Coverage
Urgent Care Center	$50 Copayment		No Coverage
Vision Care (Non-Routine) Exam	$25/$50 Copayment depending on Provider		No Coverage
X-ray and Laboratory Services (*low-tech imaging*)	100% - 0%		No Coverage

[1]Subject to Plan Year Deductible
[2]Pre-Authorization Required
[3]Age and/or Time Restrictions Apply

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1829 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1888 (October 2006), repealed LR 40:

§109. ~~Contributions~~. Prescription Drug Benefits

Network Pharmacy	Member pays
Tier 1- Generic	50% up to $30
Tier 2- Preferred	50% up to $55
Tier 3- Non-preferred	65% up to $80
Tier 4- Specialty	50% up to $80
90 day supplies for maintenance drugs from mail order OR at participating 90-day retail network pharmacies	Two and a half times the cost of your applicable co-payment
Co-Payment after the Out Of Pocket Amount of $1,500 Is Met	
Tier 1- Generic	$0
Tier 2- Preferred	$20
Tier 3- Non-preferred	$40
Tier 4- Specialty	$40

Prescription drug benefits-31 day refill
Plan pays balance of eligible expenses
Member who chooses a brand-name drug for which an approved generic version is available, pays the cost difference between the brand-name drug & the generic drug, plus the co-pay for the brand-name drug; the cost difference does not apply to the $1,500 out of pocket maximum
Medications available over-the-counter in the same prescribed strength will no longer be covered under the pharmacy plan.
Smoking Cessation Medications: Benefits are available for Prescription and over-the-counter (OTC) smoking cessation medications when prescribed by a physician. (Prescription is required for over-the-counter medications). Smoking cessation medications are covered at 100%.
This plan allows benefits for drugs and medicines approved by the Food and Drug Administration or its successor that require a prescription. Utilization management criteria may apply to specific drugs or drug categories to be determined by PBM.

OGB shall have discretion to adopt a pharmacy benefits formulary to help enrollees select the most appropriate, lowest-cost options. The formulary will be reviewed on a quarterly basis to reassess drug tiers based on the current prescription drug market. The formulary may be changed from time to time subject to any applicable advance notice requirements. The amount enrollees pay toward prescription medications will depend on whether they purchase a generic, preferred brand, non-preferred brand, or specialty drug.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1830 (October 1999), repealed by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 40:

Part V. ~~Exclusive Provider Organization (EPO) – Plan of Benefits~~ Additional Plans and Operations

Chapter 1. ~~Eligibility~~ Authority for OGB Alternative Plan Options

§101. ~~Persons to be Covered~~ OGB Authority

Pursuant to La R.S. 42:851H(1) OGB may adopt, administer, operate, or contract for all or a portion of the administration, operation, or both of a primary self-funded program or additional programs with premium rate structures and state contribution rates which are different from the primary program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

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), LR 29:336 (March 2003), LR 29:338 (March 2003), LR 32:1855 (October 2006), repealed LR 40:

Chapter 2. ~~Termination of Coverage~~ PPO Plan Structure - Magnolia Open Access Plan

§201. ~~Active Employee and Retired Employee Coverage~~ Deductibles

Deductible Amount Per Benefit Period:	Network	Non-Network
Individual:	$1,000.00	$1,000.00
Family:	$3,000.00	$3,000.00

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1809 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1860 (October 2006), repealed LR 40:

§203. ~~Dependent Coverage~~ Out of Pocket Maximums

Out-of-Pocket Maximum Per Benefit Period: *Includes All Eligible Deductibles, Coinsurance Amounts and Copayments*	Network	Non-Network

Individual:	$3,000.00	$4,000.00
Family:	$9,000.00	$12,000.00

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1809 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1860 (October 2006), repealed LR 40:

§205. Schedule of Benefits

COINSURANCE

	ACTIVE EMPLOYEES/ NON-MEDICARE RETIREES		**RETIREES WITH MEDICARE**
	Network Providers	Non-Network Providers	Network and Non-Network Providers
Physician Office Visits including surgery performed in an office setting: • General Practice • Family Practice • Internal Medicine • OB/GYN • Pediatrics	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Allied Health/Other Professional Visits: • Chiropractors • Federally Funded Qualified Rural Health Clinics • Nurse Practitioners • Retail Health Clinics • Optometrists • Physician Assistants	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Specialist (Physician) Office Visits including surgery performed in an office setting: • Physician • Podiatrist • Midwife • Audiologist • Registered Dietician • Sleep Disorder Clinic	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Ambulance Services – Ground (*for Medically Necessary Transportation only*)	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]

Ambulance Services – Air (*for Medically Necessary Transportation only*)	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Ambulatory Surgical Center and Outpatient Surgical Facility	90% - 10%[1,2]	70% - 30%[1,2]	80% - 20%[1]
Autism Spectrum Disorders (ASD)	90% - 10%[1,3]	70% - 30%[1,3]	80% - 20%[1,3]
Birth Control Devices – Insertion and Removal (*as listed in the Preventive and Wellness Care Article in the Benefit Plan)*	100% - 0%	70% - 30%[1]	Network Providers 100% - 0% Non-Network Providers 80% - 20%[1]
Cardiac Rehabilitation (*must begin within six months of qualifying event)*	90% - 10%[1,2,3]	70% - 30%[1,2,3]	80% - 20%[1,3]
Chemotherapy/Radiation Therapy	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Diabetes Treatment	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Diabetic/Nutritional Counseling – Clinics and Outpatient Facilities	90% - 10%[1]	Not Covered	80% - 20%[1]
Dialysis	90% - 10%[1,2]	70% - 30%[1,2]	80% - 20%[1]
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	90% - 10%[1,2]	70% - 30%[1,2]	80% - 20%[1]
Emergency Room (*Facility Charge*)	$150 Separate Deductible[1]; Waived if Admitted		
Emergency Medical Services (*Non-Facility Charges*)	90% - 10%[1]	90% - 10%[1]	80% - 20%[1]
Eyeglass Frames and One Pair of Eyeglass Lenses or One Pair of Contact Lenses (*purchased within six months following cataract surgery*)	Eyeglass Frames – Limited to a Maximum Benefit of $50[1,3]		
Flu shots and H1N1 vaccines (*administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair*)	100% - 0%	100% - 0%	100% - 0%

Hearing Aids (*Hearing Aids are not covered for individuals age eighteen (18) and older*)	90% - 10%[1,3]	70% - 30%[1,3]	80% - 20%[1,3]
High-Tech Imaging – Outpatient • CT Scans • MRA/MRI • Nuclear Cardiology	90% - 10%[1,2]	70% - 30%[1,2]	80% - 20%[1]
Home Health Care (*limit of 60 Visits per Plan Year)*	90% - 10%[1,2]	70% - 30%[1 ,2]	Not Covered
Hospice Care (*limit of 180 Days per Plan Year)*	80% - 20%[1,2]	70% - 30%[1 ,2]	Not Covered
Injections Received in a Physician's Office (*when no other health service is received*)	90% -10%[1]	70% - 30%[1]	80% - 20%[1]
Inpatient Hospital Admission, All Inpatient Hospital Services Included *Per Day Copayment* *Day Maximum* *Coinsurance*	 $0 Not Applicable 90% - 10%[1,2]	 $50 5 Days 70% - 30%[1,2]	 $0 Not Applicable 80% - 20%[1]
Inpatient and Outpatient Professional Services	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Mastectomy Bras – Ortho-Mammary Surgical (*limit of three (3) per Plan Year*)	90% - 10%[1,2]	70% - 30%[1,2]	80% - 20%[1]
Mental Health/Substance Abuse – Inpatient Treatment *Per Day Copayment* *Day Maximum* *Coinsurance*	 $0 Not Applicable 90% - 10%[1,2]	 $50 5 Days 70% - 30%[1,2]	 $0 Not Applicable 80% - 20%[1]
Mental Health/Substance Abuse – Outpatient Treatment	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Newborn – Sick, Services Excluding Facility	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Newborn – Sick, Facility *Per Day Copayment* *Day Maximum*	 $0 Not Applicable	 $50 5 Days	 $0 Not Applicable

Coinsurance	90% - 10%[1,2]	70% - 30%[1,2]	80% - 20%[1]
Oral Surgery for Impacted Teeth (*Authorization not required when performed in Physician's office*)	90% - 10%[1,2]	70% - 30%[1,2]	80% - 20%[1]
Pregnancy Care – Physician Services	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Preventive Care – Services include screening to detect illness or health risks during a Physician office visit. The Covered Services are based on prevailing medical standards and may vary according to age and family history. (*For a complete list of benefits, refer to the Preventive and Wellness Care Article in the Benefit Plan.*)	100% - 0%[3]	70% - 30%[1,3]	Network 100% - 0[3] Non-Network 80% - 20%[1,3]
Rehabilitation Services – Outpatient: • Speech • Physical/Occupational (*Limited to 50 Visits Combined PT/OT per Plan Year. Authorization required for visits over the Combined limit of 50.)* *(Visit limits do not apply when services are provided for Autism Spectrum Disorders)*	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Skilled Nursing Facility (*limit 90 days per Plan Year*)	90% - 10%[1,2]	70% - 30%[1,2]	80% - 20%[1]
Sonograms and Ultrasounds (*Outpatient*)	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Urgent Care Center	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Vision Care (Non-Routine) Exam	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
X-ray and Laboratory Services (*low-tech imaging*)	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]

[1]Subject to Plan Year Deductible

[2]Pre-Authorization Required

[3]Age and/or Time Restrictions Apply

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

§207. ~~Eligible Expenses~~ Prescription Drug Benefits

Network Pharmacy	Member pays
Tier 1- Generic	50% up to $30
Tier 2- Preferred	50% up to $55
Tier 3- Non-preferred	65% up to $80
Tier 4- Specialty	50% up to $80
90 day supplies for maintenance drugs from mail order OR at participating 90-day retail network pharmacies	Two and a half times the cost of your applicable co-payment
Co-Payment after the Out Of Pocket Amount of $1,500 Is Met	
Tier 1- Generic	$0
Tier 2- Preferred	$20
Tier 3- Non-preferred	$40
Tier 4- Specialty	$40
Prescription drug benefits-31 day refill	
Plan pays balance of eligible expenses	
Member who chooses a brand-name drug for which an approved generic version is available, pays the cost difference between the brand-name drug & the generic drug, plus the co-pay for the brand-name drug; the cost difference does not apply to the $1,500 out of pocket maximum	
Medications available over-the-counter in the same prescribed strength will no longer be covered under the pharmacy plan.	
Smoking Cessation Medications: Benefits are available for Prescription and over-the-counter (OTC) smoking cessation medications when prescribed by a physician. (Prescription is required for over-the-counter medications). Smoking cessation medications are covered at 100%.	
This plan allows benefits for drugs and medicines approved by the Food and Drug Administration or its successor that require a prescription. Utilization management criteria may apply to specific drugs or drug categories to be determined by PBM.	

OGB shall have discretion to adopt a pharmacy benefits formulary to help enrollees select the most appropriate, lowest-cost options. The formulary will be reviewed on a quarterly basis to reassess drug tiers based on the current prescription drug market. The formulary may be changed from time to time subject to any applicable advance notice requirements. The amount enrollees pay toward prescription medications will depend on whether they purchase a generic, preferred brand, non-preferred brand, or specialty drug.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

Chapter 3. ~~Medical Benefits~~ Narrow Network HMO Plan Structure - Magnolia Local Plan (in certain geographical areas)

§301. ~~Eligible Expenses~~ Deductibles

Deductible Amount Per Benefit Period:

Individual:

Network Providers: $500.00

Non-Network Providers: No Coverage

Family Unit Maximum:

Network Providers: $1,500.00

Non-Network Providers: No Coverage

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees, 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), LR 29:334, 338 (March 2003), LR 30:1190 (June 2004), LR 31:440 (February 2005), LR 32:1860 (October 2006), LR 32:1898 (October 2006), LR 34:646 (April 2008), LR 34:647 (April 2008), effective May 1, 2008, LR 34:2563 (December 2008), effective January 1, 2009, repealed LR 40:

§303. ~~Fee Schedule~~ Out of Pocket Maximums

Out-of-Pocket Maximum Per Benefit Period (Includes All Eligible Copayments, Coinsurance Amounts and Deductibles):

Individual:

Network Providers: $3,000.00

Non-Network Providers: No Coverage

Family:

Network Providers: $9,000.00

Non-Network Providers: No Coverage

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1811 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1862 (October 2006), LR 34:646 (April 2008), repealed LR 40:

§305. ~~Automated Claims Adjusting~~ Schedule of Benefits

COPAYMENTS and COINSURANCE

	NETWORK PROVIDERS		**NON-NETWORK PROVIDERS**
Physician Office Visits including surgery performed in an office setting: • General Practice • Family Practice • Internal Medicine • OB/GYN • Pediatrics	$25 Copayment per Visit		No Coverage
Allied Health/Other Professional Visits: • Chiropractors • Federally Funded Qualified Rural Health Clinics • Nurse Practitioners • Retail Health Clinics • Physician Assistants	$25 Copayment per Visit		No Coverage

Specialist Office Visits including surgery performed in an office setting: • Physician • Podiatrist • Optometrist • Midwife • Audiologist • Registered Dietician • Sleep Disorder Clinic	$50 Copayment per Visit		No Coverage
Ambulance Services – Ground (*for Emergency Medical Transportation only*)	$50 Copayment		No Coverage
Ambulance Services – Air (*for Emergency Medical Transportation only*)	$250 Copayment		No Coverage
Ambulatory Surgical Center and Outpatient Surgical Facility	$100 Copayment[2]		No Coverage
Autism Spectrum Disorders (ASD)	$25/$50 Copayment[3] per Visit depending on Provider		No Coverage
Birth Control Devices – Insertion and Removal (*as listed in the Preventive and Wellness Article in the Benefit Plan.*)	100% - 0%		No Coverage
Cardiac Rehabilitation (*limit of 48 visits per Plan Year*)	$25/$50 Copayment per day depending on Provider $50 Copayment – Outpatient Facility[2]		No Coverage
Chemotherapy/Radiation Therapy (*Authorization not required when performed in Physician's office*)	Office – $25 Copayment per Visit Outpatient Facility 100% - 0%[1,2]		No Coverage
Diabetes Treatment	80% - 20%[1]		No Coverage
Diabetic/Nutritional Counseling – Clinics and Outpatient Facilities	$25 Copayment		No Coverage
Dialysis	100% - 0%[1,2]		No Coverage
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	80% - 20%[1,2] of first $5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of $5,000 per Plan Year		No Coverage
Emergency Room (*Facility Charge*)	$150 Copayment; Waived if Admitted		

Emergency Medical Services (*Non-Facility Charges*)	100% - 0%[1]		100% - 0%[1]
Eyeglass Frames and One Pair of Eyeglass Lenses or One Pair of Contact Lenses (*purchased within six months following cataract surgery*)	Eyeglass Frames – Limited to a Maximum Benefit of $50[1,3]		No Coverage
Flu shots and H1N1 vaccines (*administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair*)	100% - 0%		No Coverage
Hearing Aids (*Hearing Aids are not covered for individuals age eighteen (18) and older.*)	80% - 20%[1,3]		No Coverage
Hearing Impaired Interpreter expense	100% - 0%[1]		No Coverage
High-Tech Imaging – Outpatient • CT Scans • MRA/MRI • Nuclear Cardiology • PET/SPECT Scans	$50 Copayment[2]		No Coverage
Home Health Care (*limit of 60 Visits per Plan Year*)	100% - 0%[1,2]		No Coverage
Hospice Care (*limit of 180 Days per Plan Year*)	100% - 0%[1,2]		No Coverage
Injections Received in a Physician's Office (*allergy and allergy serum*)	100% - 0%[1]		No Coverage
Inpatient Hospital Admission, All Inpatient Hospital Services Included	$100 Copayment per day[2], maximum of $300 per Admission		No Coverage
Inpatient and Outpatient Professional Services for Which a Copayment Is Not Applicable	100% - 0%[1]		No Coverage
Mastectomy Bras – Ortho-Mammary Surgical (*limited to two (2) per Plan Year*)	80% - 20%[1,2] of first $5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of $5,000 per Plan Year		No Coverage
Mental Health/Substance Abuse – Inpatient Treatment	$100 Copayment per day[2], maximum of $300 per Admission		No Coverage
Mental Health/Substance Abuse – Outpatient Treatment	$25 Copayment per Visit		No Coverage
Newborn – Sick, Services excluding Facility	100% - 0%[1]		No Coverage

Newborn – Sick, Facility	$100 Copayment per day[2], maximum of $300 per Admission		No Coverage
Oral Surgery (*Authorization not required when performed in Physician's office*)	100% - 0%[1,2]		No Coverage
Pregnancy Care – Physician Services	$90 Copayment per pregnancy		No Coverage
Preventive Care – Services include screening to detect illness or health risks during a Physician office visit. The Covered Services are based on prevailing medical standards and may vary according to age and family history. (*For a complete list of benefits, refer to the Preventive and Wellness Article in the Benefit Plan.*)	100% - 0%[3]		No Coverage
Rehabilitation Services – Outpatient: • Physical/Occupational (*Limited to 50 Visits Combined PT/OT per Plan Year. Authorization required for visits over the Combined limit of 50.*) • Speech • Cognitive • Hearing Therapy	$25 Copayment per Visit		No Coverage
Skilled Nursing Facility – Network (*limit of 90 days per Plan Year*)	$100 Copayment per day[2], maximum of $300 per Admission		No Coverage
Sonograms and Ultrasounds (*Outpatient*)	$50 Copayment		No Coverage
Urgent Care Center	$50 Copayment		No Coverage
Vision Care (Non-Routine) Exam	$25/$50 Copayment depending on Provider		No Coverage
X-ray and Laboratory Services (*low-tech imaging*)	100% - 0%		No Coverage

[1]Subject to Plan Year Deductible

[2]Pre-Authorization Required

[3]Age and/or Time Restrictions Apply

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1811 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1862 (October 2006), repealed LR 40:

§307. ~~Utilization Review—Pre-Admission Certification, Continued Stay Review~~ Prescription Drug Benefits

Repealed.

Network Pharmacy	Member pays

Tier 1- Generic	50% up to $30
Tier 2- Preferred	50% up to $55
Tier 3- Non-preferred	65% up to $80
Tier 4- Specialty	50% up to $80
90 day supplies for maintenance drugs from mail order OR at participating 90-day retail network pharmacies	Two and a half times the cost of your applicable co-payment
Co-Payment after the Out Of Pocket Amount of $1,500 Is Met	
Tier 1- Generic	$0
Tier 2- Preferred	$20
Tier 3- Non-preferred	$40
Tier 4- Specialty	$40
Prescription drug benefits-31 day refill	
Plan pays balance of eligible expenses	
Member who chooses a brand-name drug for which an approved generic version is available, pays the cost difference between the brand-name drug & the generic drug, plus the co-pay for the brand-name drug; the cost difference does not apply to the $1,500 out of pocket maximum	
Medications available over-the-counter in the same prescribed strength will no longer be covered under the pharmacy plan.	
Smoking Cessation Medications: Benefits are available for Prescription and over-the-counter (OTC) smoking cessation medications when prescribed by a physician. (Prescription is required for over-the-counter medications). Smoking cessation medications are covered at 100%.	
This plan allows benefits for drugs and medicines approved by the Food and Drug Administration or its successor that require a prescription. Utilization management criteria may apply to specific drugs or drug categories to be determined by PBM.	

OGB shall have discretion to adopt a pharmacy benefits formulary to help enrollees select the most appropriate, lowest-cost options. The formulary will be reviewed on a quarterly basis to reassess drug tiers based on the current prescription drug market. The formulary may be changed from time to time subject to any applicable advance notice requirements. The amount enrollees pay toward prescription medications will depend on whether they purchase a generic, preferred brand, non-preferred brand, or specialty drug.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1812 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1862 (October 2006), repealed LR 40:

Chapter 4. ~~Uniform Provisions~~ PPO/Consumer-Driven Health Plan Structure - Pelican HSA 775 Plan

§401. ~~Statement of Contractual Agreement~~ Deductibles

Deductible Amount Per Benefit Period:	Network	Non-Network
Individual:	$2,000.00	$4,000.00
Family:	$4,000.00	$8,000.00
Coinsurance:	Plan	Plan Participant
Network Providers	80%	20%
Non-Network Providers	60%	40%

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

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 32:1865 (October 2006), repealed LR 40:

§403. ~~Properly Submitted Claim~~ Out of Pocket Maximums

Out-of-Pocket Maximum Per Benefit Period:

Includes All Eligible Deductibles, Coinsurance Amounts and Prescription Drug Copayments		
	Network	**Non-Network**
Individual	$5,000.00	$10,000.00
Family	$10,000.00	$20,000.00

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

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 32:1865 (October 2006), repealed LR 40:

§405. ~~When Claims Must Be Filed~~ Schedule of Benefits

		COINSURANCE	
	NETWORK PROVIDERS		**NON-NETWORK PROVIDERS**
Physician's Office Visits including surgery performed in an office setting: • General Practice • Family Practice • Internal Medicine • OB/GYN • Pediatrics	80% - 20%[1]		60% - 40%[1]
Allied Health/Other Office Visits: • Chiropractors • Federally Funded Qualified Rural Health Clinics • Retail Health Clinics • Nurse Practitioners • Physician's Assistants	80% - 20%[1]		60% - 40%[1]
Specialist Office Visits including surgery performed in an office setting: • Physician • Podiatrist • Optometrist • Midwife • Audiologist • Registered Dietician • Sleep Disorder Clinic	80% - 20%[1]		60% - 40%[1]
Ambulance Services (*for Emergency Medical Transportation Only*) • Ground Transportation • Air Ambulance	80% - 20%[1]		80% - 20%[1]
Ambulatory Surgical Center and Outpatient Surgical Facility	80% - 20%[1,2]		60% - 40%[1,2]

	COINSURANCE		
	NETWORK PROVIDERS		**NON-NETWORK PROVIDERS**
Autism Spectrum Disorders (ASD) – Office Visits	80% - 20%[1,3]		60% - 40%[1,3]
Autism Spectrum Disorders (ASD) – Inpatient Hospital	80% - 20%[1,2]		60% - 40%[1,2]
Birth Control Devices – Insertion and Removal (*as listed in the Preventive and Wellness Article in the Benefit Plan*)	100% - 0%		60% - 40%[1]
Cardiac Rehabilitation (*must begin within six months of qualifying event; limited to 26 visits per Plan Year*)	80% - 20%[1,2,3]		60% - 40%[1,2,3]
Chemotherapy/Radiation Therapy (*Authorization not required when performed in Physician's office*)	80% - 20%[1,2]		60% - 40%[1,2]
Diabetes Treatment	80% - 20%[1]		60% - 40%[1]
Diabetic/Nutritional Counseling – Clinics and Outpatient Facilities	80% - 20%[1]		Not Covered
Dialysis	80% - 20%[1,2]		60% - 40%[1,2]
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	80% - 20%[1,2]		60% - 40%[1,2]
Emergency Room (*Facility Charge*)	80% - 20%[1]		80% - 20%[1]
Emergency Medical Services (*Non-Facility Charge*)	80% - 20%[1]		80% - 20%[1]
Flu Shots and H1N1 vaccines (administered *at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair*)	100% - 0%		100% - 0%
Hearing Aids (*Hearing Aids are not covered for individuals age eighteen (18) and older*)	80% - 20%[1,3]		Not Covered
High-Tech Imaging – Outpatient[2] (*CT Scans, MRI/MRA, Nuclear Cardiology, PET/SPECT Scans*)	80% - 20%[1,2]		60% - 40%[1,2]
Home Health Care (*limit of 60 Visits per Plan Year, combination of Network and Non-Network) (one Visit = 4 hours*)	80% - 20%[1,2]		60% - 40%[1,2]
Hospice Care (*limit of 180 Days per Plan Year, combination of Network and Non-Network*)	80% - 20%[1,2]		60% - 40%[1,2]

	COINSURANCE		
	NETWORK PROVIDERS		**NON-NETWORK PROVIDERS**
Injections Received in a Physician's Office (*when no other health service is received*)	80% - 20%[1] per injection		60% - 40%[1] per injection
Inpatient Hospital Admission (*all Inpatient Hospital services included*)	80% - 20%[1,2]		60% - 40%[1,2]
Inpatient and Outpatient Professional Services	80% - 20%[1]		60% - 40%[1]
Mastectomy Bras – Ortho-Mammary Surgical (*limited to two (2) per Plan Year*)	80% - 20%[1,2]		60% - 40%[1,2]
Mental Health/Substance Abuse – Inpatient Treatment	80% - 20%[1,2]		60% - 40%[1,2]
Mental Health/Substance Abuse – Outpatient Treatment	80% - 20%[1]		60% - 40%[1]
Newborn – Sick, Services excluding Facility	80% - 20%[1]		60% - 40%[1]
Newborn – Sick, Facility	80% - 20%[1,2]		60% - 40%[1,2]
Oral Surgery for Impacted Teeth (*Authorization not required when performed in Physician's office*)	80% - 20%[1,2]		60% - 40%[1,2]
Pregnancy Care – Physician Services	80% - 20%[1]		60% - 40%[1]
Preventive Care – Services include screening to detect illness or health risks during a Physician office visit. The Covered Services are based on prevailing medical standards and may vary according to age and family history. (*For a complete list of benefits, refer to the Preventive and Wellness/Routine Care Article in the Benefit Plan*.)	100% - 0%[3]		100% - 0%[3]
Rehabilitation Services – Outpatient: • Physical/Occupational (*Limited to 50 Visits Combined PT/OT per Plan Year. Authorization required for visits over the Combined limit of 50.)* • Speech (*Visit limits are a combination of Network and Non-Network Benefits*; *visit limits do not apply when services are provided for Autism Spectrum Disorders.*)	80% - 20%[1]		60% - 40%[1]
Skilled Nursing Facility (*limit 90 Days per Plan Year*)	80% - 20%[1,2]		60% - 40%[1,2]

	COINSURANCE		
	NETWORK PROVIDERS		**NON-NETWORK PROVIDERS**
Sonograms and Ultrasounds – Outpatient	80% - 20%[1]		60% - 40%[1]
Urgent Care Center	80% - 20%[1]		60% - 40%[1]
Vision Care (Non-Routine) Exam	80% - 20%[1]		60% - 40%[1]
X-Ray and Laboratory Services (*low-tech imaging*)	80% - 20%[1]		60% - 40%[1]

[1]Subject to Plan Year Deductible
[2]Pre-Authorization Required
[3]Age and/or Time Restrictions Apply

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

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), LR 32:1865 (October 2006), repealed LR 40:

§407. ~~Right to Receive and Release Information~~ Prescription Drug Benefits

Network Pharmacy	Member pays
Generic	$10 co-pay
Preferred	$25 co-pay
Non-preferred	$50 co-pay
Specialty	$50 co-pay
Prescription drug benefits-31 day refill	
Maintenance drugs: not subject to deductible; subject to applicate co-payments above.	
Plan pays balance of eligible expenses	
Member who chooses a brand-name drug for which an approved generic version is available, pays the cost difference between the brand-name drug & the generic drug, plus the co-pay for the brand-name drug	
Medications available over-the-counter in the same prescribed strength will no longer be covered under the pharmacy plan.	
Smoking Cessation Medications: Benefits are available for Prescription and over-the-counter (OTC) smoking cessation medications when prescribed by a physician. (Prescription is required for over-the-counter medications). Smoking cessation medications are covered at 100%.	
This plan allows benefits for drugs and medicines approved by the Food and Drug Administration or its successor that require a prescription. Utilization management criteria may apply to specific drugs or drug categories to be determined by PBM.	

OGB shall have discretion to adopt a pharmacy benefits formulary to help enrollees select the most appropriate, lowest-cost options. The formulary will be reviewed on a quarterly basis to reassess drug tiers based on the current prescription drug market. The formulary may be changed from time to time subject to any applicable advance

notice requirements. The amount enrollees pay toward prescription medications will depend on whether they purchase a generic, preferred brand, non-preferred brand, or specialty drug.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

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 32:1865 (October 2006), repealed LR 40:

Chapter 5. ~~Claims Review and Appeal~~ PPO/Consumer-Driven Health Plan Structure - Pelican HRA 1000 Plan

§501. ~~Administrative Review~~ Deductibles

Deductible Amount Per Benefit Period:	Network	Non-Network
Individual:	$2,000.00	$4,000.00
Family:	$4,000.00	$8,000.00
Coinsurance:	Plan	Plan Participant
Network Providers	80%	20%
Non-Network Providers	60%	40%

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

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), repealed LR 40:

§503. ~~Appeals from Medical Necessity Determinations~~ Out of Pocket Maximums

Out-of-Pocket Maximum Per Benefit Period:

Includes All Eligible Deductibles, Coinsurance Amounts and Copayments		
	Network	**Non-Network**
Individual	$5,000.00	$10,000.00
Family	$10,000.00	$20,000.00

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

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), repealed LR 40:

§505. Schedule of Benefits

	COINSURANCE		
	NETWORK PROVIDERS		**NON-NETWORK PROVIDERS**
Physician's Office Visits including surgery performed in an office setting: • General Practice • Family Practice • Internal Medicine • OB/GYN • Pediatrics	80% - 20%[1]		60% - 40%[1]

	COINSURANCE		
	NETWORK PROVIDERS		**NON-NETWORK PROVIDERS**
Allied Health/Other Office Visits: • Chiropractors • Federally Funded Qualified Rural Health Clinics • Retail Health Clinics • Nurse Practitioners • Physician's Assistants	80% - 20%[1]		60% - 40%[1]
Specialist Office Visits including surgery performed in an office setting: • Physician • Podiatrist • Optometrist • Midwife • Audiologist • Registered Dietician • Sleep Disorder Clinic	80% - 20%[1]		60% - 40%[1]
Ambulance Services (*for Emergency Medical Transportation Only*) • Ground Transportation • Air Ambulance	80% - 20%[1]		80% - 20%[1]
Ambulatory Surgical Center and Outpatient Surgical Facility	80% - 20%[1,2]		60% - 40%[1,2]
Autism Spectrum Disorders (ASD) – Office Visits	80% - 20%[1,3]		60% - 40%[1,3]
Autism Spectrum Disorders (ASD) – Inpatient Hospital	80% - 20%[1,2]		60% - 40%[1,2]
Birth Control Devices – Insertion and Removal (*as listed in the Preventive and Wellness Article in the Benefit Plan*)	100% - 0%		60% - 40%[1]
Cardiac Rehabilitation (*must begin within six months of qualifying event; limited to 26 visits per Plan Year*)	80% - 20%[1,2,3]		60% - 40%[1,2,3]
Chemotherapy/Radiation Therapy (*Authorization not required when performed in Physician's office*)	80% - 20%[1,2]		60% - 40%[1,2]
Diabetes Treatment	80% - 20%[1]		60% - 40%[1]
Diabetic/Nutritional Counseling – Clinics and Outpatient Facilities	80% - 20%[1]		Not Covered

	COINSURANCE		
	NETWORK PROVIDERS		**NON-NETWORK PROVIDERS**
Dialysis	80% - 20%[1,2]		60% - 40%[1,2]
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	80% - 20%[1,2]		60% - 40%[1,2]
Emergency Room (*Facility Charge*)	80% - 20%[1]		80% - 20%[1]
Emergency Medical Services (*Non-Facility Charge*)	80% - 20%[1]		80% - 20%[1]
Flu Shots and H1N1 vaccines (*administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair*)	100% - 0%		100% - 0%
Hearing Aids (*Hearing Aids are not covered for individuals age eighteen (18) and older*)	80% - 20%[1,3]		Not Covered
High-Tech Imaging – Outpatient (*CT Scans, MRI/MRA, Nuclear Cardiology, PET/SPECT Scans*)	80% - 20%[1,2]		60% - 40%[1,2]
Home Health Care (*limit of 60 Visits per Plan Year, combination of Network and Non-Network) (one Visit = 4 hours*)	80% - 20%[1,2]		60% - 40%[1,2]
Hospice Care (*limit of 180 Days per Plan Year, combination of Network and Non-Network*)	80% - 20%[1,2]		60% - 40%[1,2]
Injections Received in a Physician's Office (*when no other health service is received*)	80% - 20%[1] per injection		60% - 40%[1] per injection
Inpatient Hospital Admission (*all Inpatient Hospital services included*)	80% - 20%[1,2]		60% - 40%[1,2]
Inpatient and Outpatient Professional Services	80% - 20%[1]		60% - 40%[1]
Mastectomy Bras – Ortho-Mammary Surgical (*limited to two (2) per Plan Year*)	80% - 20%[1,2]		60% - 40%[1,2]
Mental Health/Substance Abuse – Inpatient Treatment	80% - 20%[1,2]		60% - 40%[1,2]
Mental Health/Substance Abuse – Outpatient Treatment	80% - 20%[1]		60% - 40%[1]
Newborn – Sick, Services excluding Facility	80% - 20%[1]		60% - 40%[1]
Newborn – Sick, Facility	80% - 20%[1,2]		60% - 40%[1,2]

	COINSURANCE		
	NETWORK PROVIDERS		**NON-NETWORK PROVIDERS**
Oral Surgery for Impacted Teeth (*Authorization not required when performed in Physician's office*)	80% - 20%[1,2]		60% - 40%[1,2]
Pregnancy Care – Physician Services	80% - 20%[1]		60% - 40%[1]
Preventive Care – Services include screening to detect illness or health risks during a Physician office visit. The Covered Services are based on prevailing medical standards and may vary according to age and family history. (*For a complete list of benefits, refer to the Preventive and Wellness/Routine Care Article in the Benefit Plan*.)	100% - 0%[3]		100% - 0%[3]
Rehabilitation Services – Outpatient: • Physical/Occupational (*Limited to 50 Visits Combined PT/OT per Plan Year. Authorization required for visits over the Combined limit of 50.*) • Speech (*Visit limits are a combination of Network and Non-Network Benefits*; *visit limits do not apply when services are provided for Autism Spectrum Disorders.*)	80% - 20%[1]		60% - 40%[1]
Skilled Nursing Facility (*limit 90 Days per Plan Year*)	80% - 20%[1,2]		60% - 40%[1,2]
Sonograms and Ultrasounds – Outpatient	80% - 20%[1]		60% - 40%[1]
Urgent Care Center	80% - 20%[1]		60% - 40%[1]
Vision Care (Non-Routine) Exam	80% - 20%[1]		60% - 40%[1]
X-Ray and Laboratory Services (*low-tech imaging*)	80% - 20%[1]		60% - 40%[1]

[1]Subject to Plan Year Deductible

[2]Pre-Authorization Required

[3]Age and/or Time Restrictions Apply

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1820 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:335 (March 2003), LR 32:1866 (October 2006), LR 35:67 (January 2009), repealed LR 40:

§507. ~~Comprehensive Medical Benefits~~ Prescription Drug Benefits

Network Pharmacy	Member pays
Tier 1- Generic	50% up to $30
Tier 2- Preferred	50% up to $55
Tier 3- Non-preferred	65% up to $80
Tier 4- Specialty	50% up to $80
90 day supplies for maintenance drugs from mail order OR at participating 90-day retail network pharmacies	Two and a half times the cost of your applicable co-payment
Co-Payment after the Out Of Pocket Amount of $1,500 Is Met	
Tier 1- Generic	$0
Tier 2- Preferred	$20
Tier 3- Non-preferred	$40
Tier 4- Specialty	$40
Prescription drug benefits-31 day refill	
Maintenance drugs: not subject to deductible; subject to applicate co-payments above.	
Plan pays balance of eligible expenses	
Member who chooses a brand-name drug for which an approved generic version is available, pays the cost difference between the brand-name drug & the generic drug, plus the co-pay for the brand-name drug; the cost difference does not apply to the $1,500 out of pocket maximum	
Medications available over-the-counter in the same prescribed strength will no longer be covered under the pharmacy plan.	
Smoking Cessation Medications: Benefits are available for Prescription and over-the-counter (OTC) smoking cessation medications when prescribed by a physician. (Prescription is required for over-the-counter medications). Smoking cessation medications are covered at 100%.	
This plan allows benefits for drugs and medicines approved by the Food and Drug Administration or its successor that require a prescription. Utilization management criteria may apply to specific drugs or drug categories to be determined by PBM.	

OGB shall have discretion to adopt a pharmacy benefits formulary to help enrollees select the most appropriate, lowest-cost options. The formulary will be reviewed on a quarterly basis to reassess drug tiers based on the current prescription drug market. The formulary may be changed from time to time subject to any applicable advance notice requirements. The amount enrollees pay toward prescription medications will depend on whether they purchase a generic, preferred brand, non-preferred brand, or specialty drug.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1820 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:335 (March 2003), LR 32:1866 (October 2006), LR 35:67 (January 2009), repealed LR 40:

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this Rule will have no impact on family functioning, stability and autonomy as described in R.S. 49:972.

Poverty Impact Statement

Because the impact of the proposed action is based on the plan selected by each individual enrollee, the impact is indeterminable as to:

1. household income, assets, and financial security;
2. early childhood or educational development;
3. employment and workforce development;

4. taxes and tax credits; or
5. child and dependent care, housing, health care, nutrition, transportation, and utilities assistance.

Notwithstanding, OGB is offering plans that may result in a positive impact on the above items.

Small Business Statement

The impact of the proposed Rule on small businesses as defined in the Regulatory Flexibility Act has been considered. It is estimated that the proposed action is not expected to have a significant adverse impact on small businesses. The agency, consistent with health, safety, environmental and economic welfare factors has considered and, where possible, utilized regulatory methods in the drafting of the proposed Rule that will accomplish the objectives of applicable statutes while minimizing the adverse impact of the proposed Rule on small businesses.

Provider Impact Statement

The proposed Rule should not have any known or foreseeable impact on providers as defined by HCR 170 of 2014 Regular Legislative Session. In particular, there should be no known or foreseeable effect on:

1. the effect on the staffing level requirements or qualifications required to provide the same level of service;
2. the total direct and indirect effect on the cost to the providers to provide the same level of service; or
3. the overall effect on the ability of the provider to provide the same level of service.

Public Comments

Interested persons may submit written comments via the U.S. Mail until 4:30 p.m., October 9, 2014, to **NAME, TITLE** Office of Group Benefits, **ADDRESS.**

Public Hearing

A public hearing on this proposed Rule is scheduled **for DAY, DATE at TIME at PLACE**.

Susan T. West
Chief Executive Officer