PATIENT-CENTERED MEDICAL HOME HMO PLAN

MEMBER CERTIFICATE OF COVERAGE

OFFICE OF
GROUP
BENEFITS

VANTAGE HEALTH PLAN, INC.
Making Healthcare Work!

2013

Vantage Health Plan

A

HEALTH MAINTENANCE ORGANIZATION

OPERATED BY

Vantage Health Plan, Inc.
130 DeSiard Street, Suite 300
Monroe, LA 71201
(318) 361-0900 or (888) 823-1910
www.VHP-stategroup.com

This Certificate of Coverage ("Certificate") sets forth in detail your rights and obligations as a Member enrolled in Vantage Health Plan, Inc. ("Vantage").

It is important that you **READ YOUR CERTIFICATE CAREFULLY** and familiarize yourself with its terms and conditions. For reference purposes, a table of contents has been included on the inside of this Certificate.

In order to avoid being faced with non-payment of services, Members should always verify whether their Physician, Hospital, or pharmacy is a Participating Provider before receiving services. Services of Participating Specialty Care Providers require a written Referral from your Primary Care Physician ("PCP"). Participating Providers are subject to change at any time without prior notice.

If you receive services from an Out-of-Network Provider, the charges may be significantly more than Participating Provider fees and/or the Vantage Allowable. You may be balance billed for the cost of services exceeding the Vantage Allowable. It is the Member's responsibility to verify a provider's participation status prior to receiving services and to find out what the Vantage Allowable is for a Covered Service provided by an Out-of-Network Provider.

Health care services may be provided to the Member at a Participating health care facility by facility-based Physicians who are not Tier I or Tier II Providers in this Plan. You may be responsible for payment of all or part of the fees for those Out-of-Network services, in addition to applicable amounts due for the Deductible, Co-insurance and non-Covered Services.

If you need additional information, please contact Vantage Health Plan, Inc., 130 Desiard St., Ste. 300, Monroe, LA 71201 or by calling (318) 361-0900 or toll-free at (888) 823-1910. Questions regarding eligibility and enrollment should be directed to the Office of Group Benefits at (225) 925-6625 or toll-free at (800) 272-8451. For language assistance services, please contact Vantage's Member Services department. For the hearing impaired, please call TTY (866) 524-5144. Vantage offers some language translation, sign language, and teletypewriter (TTY) services to Members.

Table of Contents

This table of contents is designed only to help you locate answers to your questions more quickly. The table of contents does not cover every topic in this Certificate and may not list all the page numbers where references to the topics listed can be found. This table of contents does not change your benefit coverage or specifications.

WELCOME TO VANTAGE HEALTH PLAN!

You are now a Member of Vantage Health Plan, a Health Maintenance Organization (HMO). You have enrolled in the Vantage Regional HMO plan through the Office of Group Benefits ("OGB"). As a Louisiana HMO, Vantage is an active participant in helping you receive quality, comprehensive medical care at a reasonable cost.

Your Member packet contains important information that should answer most of your questions about your benefits, as well as your rights and responsibilities as a Member. Because the coverage under this Plan differs from traditional health insurance, it is important that you understand your benefits and the procedures required to receive the coverage available to you.

Please read carefully when you see this symbol. This symbol will help you identify important information and help you use this Plan. This symbol is only to assist you and does not lessen the importance or make null and void any other Plan requirements.

THIS PLAN PACKET INCLUDES THE FOLLOWING DOCUMENTS:

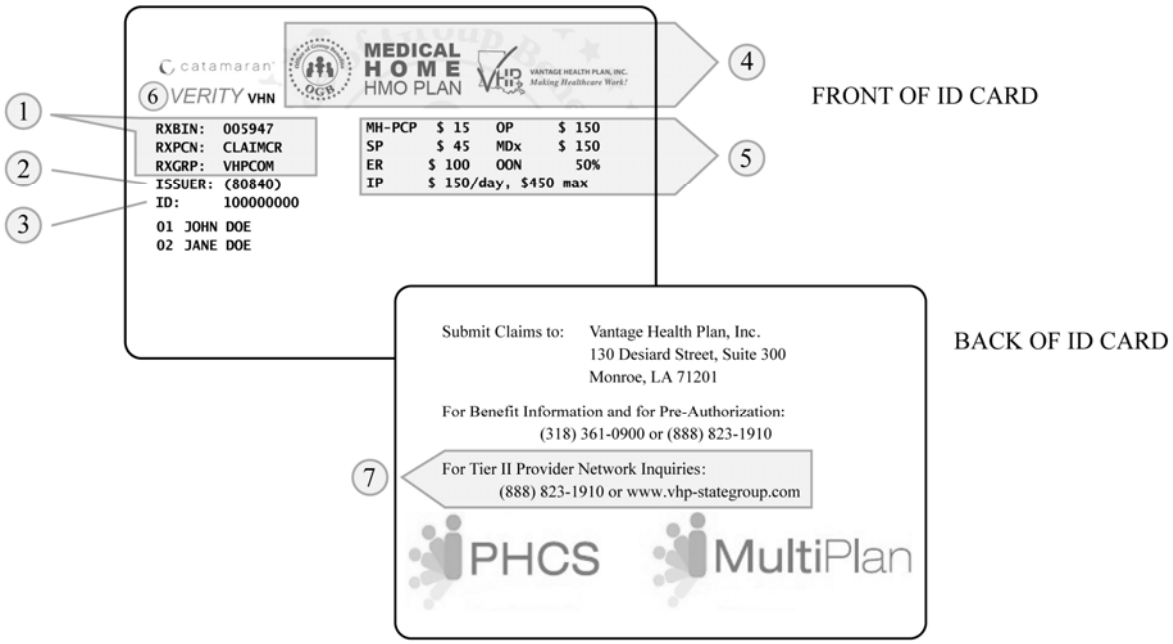
MEMBER CERTIFICATE OF COVERAGE
This Member Certificate of Coverage is based on the group contract between OGB and Vantage. Please read this Certificate carefully. This Certificate explains what is covered and what is not covered by Vantage. Any service not listed as a Covered Service is not covered.

COST SHARE SCHEDULE
This schedule (enclosed with this Certificate) details the Co-payment and Co-insurance amounts or percentages that are your financial responsibility and are based on the type of Covered Service. All Deductible and Co-insurance amounts are based on the Vantage Allowable or actual payments made after any discounts and/or reductions. Charges above the Vantage Allowable for Covered Services provided by Out-of-Network Providers do not apply to the Deductible.

IDENTIFICATION CARDS

The Vantage identification card (ID Card) is to be shown each time you or your covered Dependents receive services at a Physician's office, Hospital, other provider or pharmacy. Not showing your ID Card could result in bills being sent to you instead of to Vantage. Note: If Vantage has already mailed your Member ID Cards for the upcoming Benefit Period, this packet will not contain additional Member ID Cards.

SAMPLE MEMBER ID CARD



1. Prescription drug information for your pharmacist
2. Unique number for Vantage Health Plan, Inc.
3. Your unique Member ID number
4. Plan Name
5. Cost Share Schedule:

   MH-PCP = Medical Home Primary Care Physician
   SP = Specialist
   ER = Emergency Room
   IP = Inpatient
   OP = Outpatient
   MDx = Major Diagnostic
   OON = Out-of-Network

6. Depending on where you live, the Member ID card may have the following network logos:

   VERITY VHN

   The Verity Healthnet National network is only available as a primary provider network for Vantage Health Plan Members that work or reside in the following parishes: Pointe Coupee, West Feliciana, East Feliciana, West Baton Rouge, East Baton Rouge, Livingston, Iberville, and Ascension.

7. Tier II Provider networks are available for use by all Members. Members will pay Tier II Co-insurance in addition to the Tier I Cost Share if the Covered Service is performed by Providers in the Tier II networks (Tier II Providers).

READ THE INFORMATION IN THIS PACKET NOW, AND KEEP IT FOR FUTURE REFERENCE.

If you do not receive all of this information or if the information is incorrect, please contact Vantage Member Services at (318) 361-0900 or (888) 823-1910 immediately.

Section I: VANTAGE PATIENT-CENTERED MEDICAL HOME

The Patient-Centered Medical Home (PCMH) is an approach to providing cost effective and comprehensive primary health care for children, youth, and adults. The PCMH creates partnerships between individual patients and their personal Physicians, and when appropriate, the patient's family. Rather than being a "*gatekeeper*" who restricts patient access to services, a personal physician leverages the key attributes of the Patient-Centered Medical Home model to coordinate and facilitate the care of patients and is directly accountable to each patient.

Medical Home Primary Care Physician (MH-PCP)
Each Vantage Member has an ongoing relationship with a personal Physician trained to provide first contact and assist you in obtaining access to ongoing and comprehensive health care. The MH-PCP is your personal Physician and will work with you to coordinate all of your health care.

Vantage requires the designation of a Medical Home Primary Care Physician (MH-PCP) by all Plan Members. A MH-PCP will be assigned to coordinate your health care if you do not make a designation when you enroll. You may change your designated or assigned MH-PCP at any time by contacting Vantage. You have the right to designate any Tier I In-Network MH-PCP who is available to accept you and/or your family members as patients. For Children, you may designate a Tier I In-Network pediatrician as the MH-PCP. You do not need a Referral from Vantage or from any other person (including a MH-PCP) in order to obtain access to obstetrical or gynecological care from an In-Network Provider who specializes in obstetrics or gynecology. The In-Network Provider, however, may be required to comply with certain procedures, including obtaining Pre-Authorization from Vantage for certain services, following a pre-approved treatment plan or following procedures for making Referrals. To select a MH-PCP or to receive a list of Tier I In-Network Providers, contact Vantage Health Plan at (318) 361-0900 or (888) 823-1910.

All Vantage Members are required to select a MH-PCP upon enrollment in the Vantage Medical Home HMO Plan. Your personal Physician, or MH-PCP, leads a team of clinical health care professionals who collectively take responsibility for your immediate and ongoing health care needs. Patient-Centered Medical Home health care professionals may also include a variety of other clinical professionals, such as nurses, social workers, dieticians and nutritionists. Your MH-PCP will also be responsible for arranging appropriate care with other qualified health care professionals, Specialty Care Providers or facilities, such as radiologists, laboratories, surgeons, and Hospitals.

Your MH-PCP will assist you in providing or arranging for all of your health care needs, including acute care, Chronic care and preventive services across all elements of the complex health care system (e.g., subspecialty care, Hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by the Vantage Medical Management department which will work closely with your MH-PCP to facilitate communication among the various Participating Providers involved in your health care.

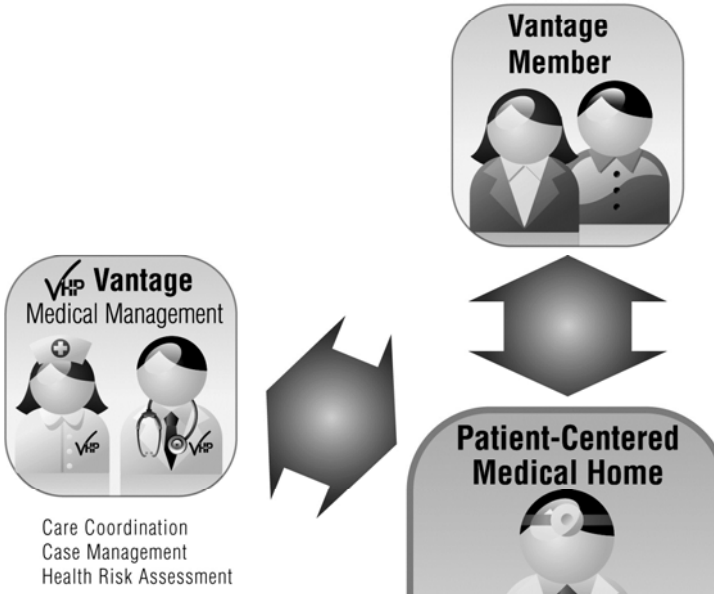
Quality and safety are hallmarks of the Patient-Centered Medical Home:

- MH-PCP's advocate for their patients to support the desired patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between Physicians, patients and the Vantage Medical Management department.
- Evidence-based medicine and clinical decision-support tools guide the providers' decision making.
- Physicians accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement programs provided by Vantage.

- Patients actively participate in decision-making, and feedback is sought to ensure patients' expectations are being met.
- Information technology is utilized to support optimal patient care, performance measurement, patient education, and enhanced communication. Electronic Medical Records (EMRs) are a fundamental aspect in case management and disease management programs as well as the ongoing coordination of care provided by Vantage to each Member enrolled in this Plan.

A simple illustration of the Vantage Patient-Centered Medical Home Model on the following page shows how each Vantage Member's care is coordinated by the MH-PCP. In the Model, you can see that Vantage Medical Management provides information and assists the MH-PCP to coordinate care, and then the MH-PCP provides additional treatment and services by facilitating access to a wide variety of Specialty Care Providers, Hospitals, outpatient services and referral centers of excellence whenever necessary.

Vantage Health Plan
PATIENT-CENTERED MEDICAL HOME MODEL
"New Name... Same Great Care and Service"



This simple illustration of the Vantage Patient-Centered Medical Home Model shows how your care is coordinated by your MH-PCP. In the Model, you can see that Vantage Medical Management provides information and assists the MH-PCP to coordinate your care, and then the MH-PCP provides additional treatment and services by facilitating access to a wide variety of specialists, hospitals, outpatient services and Referral Centers of Excellence when medically necessary.

Care Coordination
Case Management
Health Risk Assessment

Cardiology
Chiropractic
Dermatology
Ear Nose & Throat
Endocrinology
Gastroenterology
Gynecology
Hematology/Oncology
Hospitals
Home Health
Laboratories
Infusion Therapy
Neonatology
Nephrology
Obstetrics
Outpatient Centers
Occupational Therapy Centers
Orthopaedics
Pharmacy
Physical Therapy
Pulmonology
Radiology
Skilled Nursing Facility
Social Services
Speech Therapy
Surgery
Treatment Centers
Urology

Referral Centers:
Arkansas Children's Hospital
Children's Hospital in New Orleans, LA
M.D. Anderson Cancer Center
St. Jude Children's Research Hospital
University of Alabama at Birmingham Hospital
Transplant Centers

VHP229 R011210

Vantage Medical Management

Vantage assists the MH-PCP by providing additional health information and coordination data related to your health history, such as Prescription Drug coverage and medical treatments provided. Vantage collects and organizes all of the available health information for each Member. The goal of the Vantage Medical Management department is to support the MH-PCP in compiling a complete and accurate health profile of each Member and to facilitate access to whatever health care services are required to improve each Member's health status in consultation with the MH-PCP. Remember, the MH-PCP is your personal Medical Home Primary Care Physician.

A. **How to Obtain Referrals for Services Outside of your Patient-Centered Medical Home**
Your MH-PCP may need to refer you to another Participating Provider for assistance in treating your Illness or injury. Vantage will cover Medically Necessary services by a Tier I Specialty Care Provider if a Referral is obtained from your MH-PCP as required by your Plan.

Examples of Exceptions:
Referrals are not required for a routine vision examination covered once every Benefit Period. Referrals are not required for visits to a Participating OB/GYN Physician.

It is the Member's responsibility to make certain the written Referral form has been properly submitted. This is a simple procedure, but could result in nonpayment of claims if it is overlooked or handled incorrectly.

The following guidelines for the Referral process may be helpful if your MH-PCP recommends specialty care:

- Check with your MH-PCP, use your Vantage Provider Directory (the Vantage Provider Directory is subject to change at any time), or contact Vantage to be sure the Specialty Care Provider that has been recommended is a Tier I Provider.
- Your MH-PCP will handle distribution of the forms. One copy will stay in your medical record, one will be sent to the Tier I Specialty Care Provider and one is sent to Vantage. Your MH-PCP may ask you to hand-carry your Referral to the Tier I Specialty Care Provider. Be sure to present it to the office upon arrival. If your Referral was mailed to the Tier I Specialty Care Provider, make sure the office has received it before you see the doctor.

Referral forms must be submitted **prior to** receiving services. Vantage cannot accept Referrals that are dated after services have been received.

- A Specialty Care Provider cannot refer to another Specialty Care Provider.
- Be aware of the duration period of your Referral. Referrals are good for only two (2) visits. If ongoing specialty care is needed, your Specialty Care Provider may extend the duration by calling the Medical Management department at (318) 361-0900 or (888) 823-1910 if outside the local calling area.
- A Referral that originated with another insurance program before you joined Vantage will be invalid, even though it has not expired. You must obtain a new Vantage Referral in order for the services to be considered for payment under this Plan.
- Vantage offers most specialty services within its network of Participating Providers. In special circumstances, when someone must provide care other than a Participating

Provider, the visit requires Pre-Authorization by the Medical Management department. This is your responsibility.

- Written Referral forms are required for Referrals to Vantage Tier I Specialty Care Providers only. Services provided by other Vantage Participating Providers do not require a Referral form, but must be ordered by a MH-PCP and may require Pre-Authorization.

B. **Pre-Authorization**

Pre-Authorization means written authorization from Vantage before receiving certain health services. It can mean the difference between a claim being paid or denied. Pre-Authorizations help Vantage to control and monitor those health services that are most costly. Providers of services requiring a Pre-Authorization are required to assist in obtaining the Pre-Authorization, but the Member remains ultimately responsible. Pre-Authorizations and Referrals are subject to eligibility of the Member at the time services are rendered.

The same Covered Services which require Pre-Authorization for Tier I Providers also require Pre-Authorization for Tier II Providers. All Out-of-Network Covered Services except Emergency Medical Services require Pre-Authorization. This Certificate lists the services that need a Pre-Authorization in the Schedule of Covered Services and Benefits. NOTE: This list of services requiring Pre-Authorization is subject to change. You may call Member Services at (318) 361-0900 or toll-free at (888) 823-1910 for a current list of services that require Pre-Authorization.

C. **Vantage Medical Utilization Review Program**

Employers and health plans have worked to develop programs that can reasonably contain costs while maintaining the quality of care. One such program is Utilization Review.

What Is Utilization Review?

Utilization Review is a process to ensure that you, your Physician, and your health plan work together to provide quality health care that avoids unnecessary hospitalization, inconvenience, and cost. It is an added benefit to assist in making decisions about your medical care.

How Does Utilization Review Work?

When your Physician recommends that you be hospitalized, you or the Physician must call Vantage and outline the planned treatment. As you know, a Hospital is not always the most appropriate place to receive treatment and is generally more expensive. By reviewing requests for hospitalization, the Vantage Medical Management staff makes sure that a Hospital stay is Medically Necessary and appropriate for inpatient care. Many diagnostic and surgical procedures are routinely performed in an outpatient setting, which can be easier for you and less costly. Vantage will also coordinate the plan of care with your MH-PCP to ensure the services being recommended are consistent with your health history.

If elective hospitalization is planned or you know ahead of time that a Hospital stay is needed, you or your Physician must call Vantage **before** your admission. If you, your spouse, or Dependent is admitted on an emergency basis, you or your Physician must contact Vantage **within 24 hours** (or the next working day if on a weekend or holiday) of the admission.

What is the Procedure for Utilization Review?

A single phone call sets the process in motion.

When the call is made, a Vantage Medical Management nurse will request certain basic information about the patient (you, your spouse or Dependent), and the reasons for the proposed admission. Vantage uses established, Physician-approved, medical and surgical criteria to determine the Medical Necessity of all Hospital admissions.

A nurse reviewer can review and approve a request, and that is what happens in the vast majority of cases. If the Medical Management nurse has questions about the necessity of the admission, they will consult with the Vantage Medical Director (a medical doctor) who will review the medical data. The Vantage Medical Director or a nurse may also inquire further about the treatment plan by contacting the Physician recommending the admission/treatment as well as contacting your MH-PCP.

In some instances it may be determined that your care can be more appropriately provided in an outpatient setting. If so, the Medical Director will recommend alternatives to hospitalization. Your Plan provides coverage for Medically Necessary outpatient or home care services, often with lower cost to you. These options may be discussed with your Physician and MH-PCP.

If your Hospital admission is authorized, an authorization number is given to you or your Physician and the Hospital. Your continued Hospital stay is reviewed by the Medical Management nurse to determine if further inpatient care is necessary beyond the initial days certified. This will also assure appropriate discharge planning, so follow-up or home care needs can be addressed.

Is the Vantage Decision Final?
If you or your Physician disagrees with a Vantage denial, you may request an Appeal. In this situation, another Participating Physician will review the medical information. If you still disagree with the outcome, a further Appeal process is outlined in this Certificate.

What Is My Responsibility?
Your role is to share this information with your spouse or Dependent if they are covered under your health care Plan and **to show your Vantage ID Card to your Physician when a Hospital admission is being discussed**. This alerts your Physician to call Vantage if a Hospital admission is planned. Following this process is essential to ensure that a Hospital stay is covered.

How Do I Benefit From Utilization Review?
If you are paying any portion of the premiums on your health Plan, Utilization Review will help control rate increases that could result from unnecessary Hospital stays. If Vantage requires you to pay a part of the cost of treatment, Utilization Review assures that you will be treated in the most cost-effective way while maintaining quality health care. Your preadmission review program is a "win-win" benefit that promotes quality health care and reduces cost.

In Summary
Ask your Physician to call the Vantage Medical Management department to begin the Pre-Authorization process. Pre-Authorization is required for all planned, non-Emergency admissions. Emergency hospitalization must be certified the next working day after admission or when reasonably possible.

Maternity admission must be certified the next working day after admission. Pre-Authorization is required before admission for maternity care involving a scheduled Cesarean section.

Monroe (318) 361-0900
If outside the local calling area, toll-free 1-(888)-823-1910
Monday-Friday 8 a.m. - 5 p.m.

Section II: How to use this Plan

As a Patient-Centered Medical Home HMO, Vantage provides more of the comprehensive health services you need to get well and stay well. However, there are a few basic rules you must keep in mind to make sure you are receiving the full benefits of the coverage available.

Vantage Member Identification Card
When you join the Plan, you are sent Vantage Member identification cards (ID Card). Your ID Card should be kept with you at all times. Each time services are rendered, you should present your ID card. For details about Co-payments, Co-insurance or Deductible for which you are responsible, please refer to Section IV of this Certificate of Coverage, your Cost Share Schedule, or the front of your ID Card or you may contact the Member Services department at (318) 361-0900 or toll-free at (888) 823-1910.

Your ID Card is for identification purposes only. Any person receiving benefits or services to which they are not entitled will be financially responsible for any charges.

If you need extra ID Cards or lose your ID Card, please call the Member Services department. We will be happy to order you another set.

Network Design
The In-Network benefits described in this Certificate of Coverage refer to Tier I Providers. Most In-Network Providers are Tier I Providers. Vantage may contract with certain providers or provider networks even though their cost may be higher than similar Tier I Providers. These providers are listed in the Vantage Provider Directory as Tier II Providers. Because of the higher cost of the Tier II Providers, there is an additional Co-insurance payment for Members who choose to use these providers. The additional Co-insurance percentage is listed by each Tier II Provider or provider network in the Vantage Provider Directory.

Example:

Tier I Provider	**Member Pays**
Hospital A	Co-payments and Tier I In-Network Co-insurance as listed in Section IV of this Certificate of Coverage and/or the Cost Share Schedule.

Tier II Provider	**Member Pays**
Hospital B	Tier II Co-insurance in addition to the Co-payment and the Tier I In-Network Co-insurance (all of which are listed in Section IV of this Certificate of Coverage and/or the Cost Share Schedule.) This additional Tier II Co-insurance percentage is noted in the Vantage Provider Directory under the Tier II Provider section.

A Provider's status (Tier I, Tier II, In-Network Provider, Out-of-Network Provider) is subject to change at any time.

In-Network Providers cannot balance bill Members.

Member Rights and Responsibilities
As a Member of Vantage Health Plan, you have the following rights and responsibilities:

- ► A right to receive information about Vantage, its services, its Health Care Providers and your rights and responsibilities as a Member.
- ► A right to be treated with respect and recognition or your dignity and right to privacy.
- ► A right to participate with Health Care Providers in making decisions about your health care.
- ► A right to candid discussion of appropriate or Medically Necessary treatment option for your conditions, regardless of cost or benefit coverage.
- ► A right to voice grievances or Appeals about Vantage, its Health Care Providers or the care provided.
- ► A right to make recommendations regarding Vantage's Member rights and responsibilities policy.
- ► A responsibility to supply information (to the extent possible) that Vantage and its Health Care Providers need in order to provide care.
- ► A responsibility to follow treatment plans and instructions for care that you have agreed to with your Health Care Provider.
- ► A responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.

How to Obtain Emergency Care and Care After Office Hours
As a Member, it is up to you to use your Vantage coverage wisely. Vantage is not an insurance program that reimburses you for whatever health care services you may desire. Your MH-PCP will work with you to assure that you receive the medical care you need in an appropriate, cost effective manner.

Call your MH-PCP immediately when you require medical attention. Your MH-PCP can advise you of the best course of action based on his/her knowledge of your medical history and your present symptoms.

However, when a Member's medical condition of recent onset and severity, including severe pain, would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in the serious jeopardy of one's health or the health of an unborn child, serious impairment to bodily function or serious dysfunction of any bodily organ or part, the **Member should call 911 and seek Emergency Medical Services.** Emergencies do not require Pre-Authorization.

Emergency hospitalization must be authorized by Vantage on the next working day after admission or when reasonably possible. Pre-Authorization is required for all planned, non-Emergency admissions.

Maternity admission must be authorized by Vantage on the next working day after admission. Pre-Authorization is required before admission for maternity care involving a scheduled Caesarean section.

Members may visit an after-hours clinic or other facility primarily engaged in treating patients whose conditions require medical attention after normal office hours for non-Emergency Medical Services. Pre-Authorization is required for follow-up visits.

IMPORTANT RULES TO HELP YOU USE THIS PLAN:

ALWAYS obtain a written Referral from your MH-PCP **before** seeking services from a Tier I Specialty Care Provider.

ALWAYS carry your Vantage ID Card and present it **before** receiving health services.

ALWAYS pay any Co-payments **at the time** you receive services.

ALWAYS remember, there may be an **additional Tier II Co-insurance payment** required by Members who receive services from Tier II Providers.

ALWAYS remind your MH-PCP and other providers that you are a Vantage HMO Member and must be referred only to other Participating Providers.

ALWAYS remember, Covered Services provided by Out-of-Network Providers will be covered at a reduced benefit and you may be balance billed for substantial amounts. Claims for Out-of-Network Providers must be received by Vantage Health Plan within one year from the date of service.

ALWAYS obtain Pre-Authorization (written authorization **before** services are received) from the Vantage Medical Management department for those services that require Pre-Authorization. Services requiring Pre-Authorization are identified, where applicable, in *Section IV: Schedule of Covered Services & Benefits*. **The same Covered Services which require Pre-Authorization for Tier I Providers also require Pre-Authorization for Tier II Providers.** All Out-of-Network Covered Services except Emergency Medical Services require Pre-Authorization.

NOTE: This list of services requiring Pre-Authorization is subject to change. You may call Member Services at (318) 361-0900 for a current list of services that require Pre-Authorization.

This Plan offers Out-of-Network coverage. When you seek treatment from an Out-of-Network Provider, the charges may be significantly more than the Vantage Allowable. You may be balance billed for substantial amounts. You may contact Vantage's Member Services department at (318) 361-0900 to find out what the Vantage Allowable is for any given Covered Service. Charges above the Vantage Allowable incurred by a Member for Covered Services provided by Out-of-Network Providers do not apply toward the Out-of-Network Deductible.

The Vantage Member Services department is available to assist you in using this Plan. Call (318) 361-0900 or (888) 823-1910, Monday-Friday, 8:00 a.m. - 8:00 p.m. For language assistance services, please contact Vantage's Member Services department. For the hearing impaired, please call TTY (866) 524-5144. Vantage offers some language translation, sign language and teletypewriter (TTY) services to Members.

SECTION III: DEFINITIONS

Accident means bodily injury caused by a sudden and unforeseen event, definite as to time and place.

Accidental Bodily Injury means injury by an accident of external, sudden and unforeseen means.

Actively at Work means the active expenditure of time and energy by a covered Employee in the service of the Employer. Such work must be performed (1) at the Employee's usual place of employment, or as required by the Employer, and (2) for the Employer on a regular weekly schedule as set forth in the Group Enrollment Agreement under "minimum hours at work per week." A person on a scheduled vacation from work is considered Actively at Work if the person is expected to return to active work following the vacation time.

Appeal means the type of complaint a Member files with Vantage to request that Vantage reconsider and change a decision related to Covered Services, (including a denial of, reduction in, or termination of a Covered Service or a failure to make a payment in whole or in part for a Covered Service) or a rescission of coverage under this Plan.

Beneficiary means a person designated by a Participant, or by the terms of the health insurance benefit plan, who is or may become entitled to a benefit under the Plan.

Benefit Level means the level at which a Member's cost share is paid. Each level (Tier I In-Network, Tier II In-Network, and Out-of-Network) has a different cost share for the Member as indicated in Section IV of this Certificate of Coverage.

Benefit Period means the Plan Year or contract period for which benefits are covered for the Group Health Plan.

Chronic Condition or Chronic refers to a medical illness, disease or physical ailment of long duration (three (3) month duration or longer according to U.S. National Center for Health Statistics) or frequent recurrence, associated with slow progress and long continuance.

Child or Children means:

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

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

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

Co-insurance means the percentage of the Vantage Allowable the Member is required to pay based on the type of Covered Service and may be due at the time of service. Co-insurance percentages are listed in the attached Cost Share Schedule and/or in Section IV*: Schedule of Covered Services & Benefits* of

this Certificate of Coverage. Co-insurance applies before Co-payments and the Deductible, and it does not apply toward the Deductible.

Co-payment means the amount the Member is required to pay based on the type of Covered Service and is due at the time of service. Co-payment amounts are listed in the attached Cost Share Schedule and/or in Section IV*: Schedule of Covered Services & Benefits* of this Certificate of Coverage. Co-insurance applies before Co-payments.

Cost Share means the Co-payment and Co-insurance amounts or percentages that are the Member's financial responsibility and are based on the type of Covered Service.

Cost Share Schedule means the attached document that details the Co-payment, Co-insurance, Deductible and Out-of-Pocket Maximum amounts or percentages that are the Member's financial responsibility and are based on the type of Covered Service.

Cosmetic Purposes means services rendered to alter the texture or configuration of the skin, or the configuration or relationship with contiguous structures of any feature of the human body for primarily personal or emotional reasons.

Covered Service(s) means any Medically Necessary services and supplies, including Prescription Drugs, received upon the recommendation and approval of a Physician and required for the treatment of a Member, subject to the health care benefit offered by OGB to Employees as part of a Group Health Plan under an agreement with Vantage and subject to the exclusions and limitations listed elsewhere in this Certificate of Coverage.

Creditable Coverage means coverage of the Member under any Group Health Plan.

Custodial Care means care that primarily meets personal, comfort or hygiene needs and can be provided by a person without professional skills or training. It also includes care for an Illness or condition that is not expected to substantially improve.

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

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

Deductible means the amount shown in Section IV of this Certificate of Coverage and in the Cost Share Schedule that the Member must pay each Benefit Period before Out-of-Network benefits are payable under the Plan. The Deductible applies to the Out-of-Network Eligible Charges to be paid by each Member during the Benefit Period. Charges above the Vantage Allowable for services provided by Out-of-Network Providers do not apply toward the Deductible. The family Out-of-Network Deductible is cumulative, which means it can be met by one or more family Members.

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

1. The covered Employee's legal spouse;
2. A Child from Date Acquired until attainment of age 26;
3. A Child of any age who meets the criteria set forth in *Section VII: Eligibility for Coverage* herein.

Developmental Condition or Developmental Disorder refers to an impairment in normal development of language, motor, cognitive and/or motor skills, generally recognized before age eighteen (18) which is expected to continue indefinitely and involves a failure or delay in progressing through the normal developmental stages of childhood.

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

1. The covered Employee's legal Spouse - Certified copy of certificate of marriage indicating date and place of marriage;
2. Child:
    a. Natural or legally adopted Child of Member - Certified copy of birth certificate listing Member as parent or certified copy of legal acknowledgment of paternity signed by Member or certified copy of adoption decree naming Member as adoptive parent;
    b. Stepchild - Certified copy of certificate of marriage to spouse and birth certificate listing spouse as natural or adoptive parent;
    c. Child placed with your family for adoption by agency adoption or irrevocable act of surrender for private adoption - Certified copy of adoption placement order showing date of placement or copy of signed and dated irrevocable act of surrender;
    d. Child for whom you have been granted guardianship or legal custody, including provisional custody - Certified copy of the court order granting legal guardianship or custody, or the original notarized act granting provisional custody in proper statutory form and substance;
    e. Grandchild for whom you do not have legal custody or guardianship whose parent is a covered Dependent - Certified birth certificate or adoption decree showing parent of grandchild is Dependent Child and certified copy of birth certificate showing Dependent Child is parent of grandchild;
3. Child age 26 or older who is incapable of self-sustaining employment and who was covered prior to and upon attainment of age 26 - Documentation as described in 2a through 2d above together with an application for continued coverage supporting medical documentation prior to the Child's attainment of age 26 as well as additional medical documentation of Child's continuing condition periodically upon request by OGB;
4. Such other written proof of relationship to the Employee deemed sufficient by OGB.

Drug(s) refers to all Prescription Drugs and Non-prescription Drugs.

Durable Medical Equipment (DME) is an item that serves a medical purpose only and is Medically Necessary for the treatment of Illness or injury, and can withstand long-term repeated use, and is appropriate for home use.

Electronic Medical Records (EMR) is a digital information system which keeps track of medical information and provides a Physician interface that allows the Physician and other Health Care Provider(s) to enter and retrieve patient-specific medical information to support patient medical care.

Eligible Charges means the charges for Covered Services, excluding Prescription Drugs.

Emergency Medical Condition or Emergency is a medical condition of recent onset and severity, including severe pain, which would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in the serious jeopardy of one's health or the health of an unborn Child, serious impairment to bodily function or serious dysfunction of any bodily organ or part.

Emergency Medical Services are those medical services necessary to screen, evaluate, and stabilize an Emergency Medical Condition.

Employee means any full-time employee or former employee as defined by the Employer and in accordance with state law, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such Employer or members of such organization, or whose Dependents may be eligible to receive any such benefit.

Employer means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of Employees acting for an employer in such capacity.

Enrollment Date is defined as the date of enrollment of an individual in the Group Health Plan or if earlier, the first day of the Waiting Period for such enrollment.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Expedited Appeal means an Appeal related to a claim for urgent medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could 1) seriously jeopardize the life or health of the Member; or 2) jeopardize the ability of the Member to regain maximum function; or 3) in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Generic Drug means a prescribed therapeutic equivalent (approved by the FDA) of a brand name Prescription Drug that is usually available at a lower cost.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes of chromosomes.

Genetic Testing or Assessment means the examination of Genetic Information contained inside a person's cells to determine if that person has or will develop a certain disease or could pass a certain disease to his or her offspring.

Grievance means the type of complaint a Member files with Vantage for complaints related to Vantage or a Participating Provider about the quality of care received.

Group Health Plan means an employee welfare benefit plan (as defined in 29 U.S.C. Chapter 18 (ERISA)) to the extent that the plan provides medical care, including items and services paid for as medical care to Employees or their Dependents, as defined under the terms of the Plan, directly or through insurance, reimbursement or otherwise.

Health Care Provider(s) may include a Hospital, medical doctor (MD), dentist (DDS or DMD), osteopath (DO), pharmacist (RPh) or pharmacy, registered nurse (RN), nurse practitioner (CNP), physician assistant (PA), registered nurse first assistant (RNFA), occupational therapist, physical therapist, speech therapist, chiropractor, podiatrist (DPM), or anesthetist licensed by the proper regulatory agency of the state. Health Care Provider may also include a network(s) of any of the providers listed above.

Health Insurance Coverage means benefits consisting of medical or surgical services, provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care, under any Hospital or medical service policy or certificate, Hospital or medical service plan contract, preferred provider organization, or health maintenance organization contract offered by a health insurance issuer.

HIPAA means the Health Insurance Portability and Accountability Act of 1996 (U.S. Public Law 104-191) and federal regulations promulgated pursuant thereto.

Hospital means an institution engaged in providing care and treatment for sick and injured people as bed-patients, which provides care by registered, graduate nurses, on duty or on call doctors available at all times, and has on its immediate premises (except in the case of a hospital specializing in the care and treatment of Mental or Nervous Disorders) an operating room and related equipment for performing surgery.

> Hospital does not include any establishment (even though it may be called a hospital) or any part of any establishment which is primarily a place for any of the following: rest, convalescence, Custodial Care, the care or treatment of Drug addicts or alcoholics, rehabilitation, training, schooling or Occupational Therapy.

Illness means a disorder or disease of the body, or mental or nervous disorder.

In-Network means services obtained from In-Network Providers.

In-Network Provider(s) or Participating Provider(s) or Participating means those Health Care Providers who have current and valid agreements with Vantage to provide Covered Services to Members of Group Health Plans.

Late Enrollee is defined as an Employee or Dependent who enrolls under the Plan other than during: 1) the first period in which the individual is eligible to enroll under the Plan, or 2) a Special Enrollment Period.

Late Enrollment means enrollment under a Group Health Plan other than 1) the earliest date on which coverage can become effective under the terms of the Plan; or 2) a Special Enrollment Date for the individual.

Life-Threatening Illness means a disease or condition for which the likelihood of death is probable.

Medical Home Primary Care Physician (MH-PCP) means a Participating family practice, general practice, general pediatrician or general internal medicine Physician, selected by a Vantage Member, who provides the Member with entry into the health care system. The Medical Home Primary Care Physician: (1) evaluates the Member's total health needs; (2) provides personal medical care in one or more medical fields; (3) when Medically Necessary, preserves continuity of care and coordinates care with other providers of health care services; and (4) coordinates Member care with the Vantage Medical Management department.

Medical Necessity or Medically Necessary means services or supplies, which under the provisions of the contract, are determined to be (1) appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition; (2) provided for the diagnosis or direct care and treatment of the medical condition; (3) within standards of accepted medical practice within the organized medical community; (4) not primarily for the convenience of the Member, the Member's Physician or other provider; and (5) the most appropriate supply or level of service that can be safely provided.

> For Hospital stays, this means that acute care as an inpatient is necessary due to the kinds of services the Member is receiving or the severity of the Member's condition, and that safe and adequate care cannot be received as an outpatient or in a less acute care medical setting.

Medicare Opt-out Physician means any Physician who has opted-out of the Medicare program. When a physician "opts-out" of Medicare, no services provided by that individual will be covered or reimbursed by Medicare or Vantage, nor will any reimbursement be issued to a Member for items or services provided by that Physician. This Medicare opt-out list is available online at https://www.novitas-solutions.com/enrollment/optout/index.html.

Member(s) or Covered Person(s) means an active or retired Employee, his/her eligible Dependent, or any other individual eligible for coverage under a Group Health Plan for whom the necessary application forms have been completed and executed and for whom the required contribution is made.

Mental or Nervous Disorder(s) means a mental, emotional or behavioral disorder, including, but not limited to, neurosis, psychoneurosis, psychosis, personality disorder, and alcohol or Drug addiction.

Newborn means infants from the time of birth until age one (1) month or until such time as the infant is well enough to be discharged from a Hospital or a neonatal special care unit to the infant's home, whichever period is longer.

Non-prescription Drug(s) means any medicine that does not require a prescription from a Health Care Provider.

Occupational Therapy means a healthcare service to evaluate and treat individuals in order for the individual to participate in the things they want and need to do through the therapeutic use of everyday activities (occupations). Common occupational therapy interventions include helping people recovering from injury to regain skills and providing supports for older adults experiencing physical and cognitive changes.

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

Out-of-Network means services obtained from Out-of-Network Providers.

Out-of-Network Provider(s) or Non-Participating Provider(s) means those Health Care Providers who do not have a current and valid contract with Vantage at the time services are rendered.

Out-of-Pocket Maximum means the specified dollar amount listed in Section IV and in the Cost Share Schedule for which a Member is responsible for Tier I In-Network Eligible Charges. Out-of-Pocket Maximum does not include charges above the Vantage Allowable for Covered Services provided by Out-of-Network Providers. Other exclusions and limitations are described in Section IV. The family Out-of-Pocket Maximum is cumulative, which means it can be met by one or more family Members. There is no Out-of-Pocket Maximum for Tier II In-Network or Out-of-Network Eligible Charges.

Participant or Plan Participant means an Employee or Retiree who is entitled to benefits under the Plan or any Dependent of the Employee or Retiree who is entitled to benefits under the Plan.

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

Participating Provider(s) or Participating – See *In-Network Provider* definition.

Patient Protection and Affordable Care Act (PPACA) refers to the federal law enacted on March 23, 2010, along with the Health Care and Education Reconciliation Act of 2010, and all rules and regulations issued thereunder. This law is also sometimes referred to as the Healthcare Reform Law.

Physical Therapy means a healthcare service including evaluation and treatment of any physical or medical condition to restore normal function of the neuromuscular, musculoskeletal, cardiovascular and/or integumentary systems or prevent disability with the use of physical or mechanical means, including therapeutic exercise, mobilization, passive manipulation, therapeutic modalities and activities.

Physician means a medical doctor (MD) or osteopath (DO).

Placement for Adoption means the assumption and retention of a legal obligation for total or partial support of a Child in anticipation of adoption of such Child. The Child's placement with such person ends upon the termination of such legal obligation.

Plan means the Group Health Plan offered in the Certificate of Coverage.

Plan Administrator refers to the party responsible for administering the Group Health Plan for the exclusive benefit of the Members, including an Employer's third party administrator (TPA).

Plan Drug Formulary means a comprehensive listing of Drugs covered by this Plan.

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

Pre-Authorization means written authorization from Vantage before receiving certain health services.

Prescription Drug(s) means any medicine that requires a prescription from a Health Care Provider who is authorized by federal or state law to prescribe or refill the medicine.

Prosthetic Device or Prosthesis means an artificial limb designed to maximize function, stability, and safety of the patient. Prosthetic device or prosthesis also means an artificial medical device that is not surgically implanted and that is used to replace a missing limb. The term does not include artificial eyes, ears, nose, dental appliances, ostomy products, or devices such as eyelashes or wigs.

Reconstructive Services means reparative or therapeutic surgery or services done to restore the patient's function and appearance to pre-injury or pre-Illness state.

Recurrent Condition means defective state of health returning or happening time after time.

Referral means a written form provided to you by your MH-PCP that is required for the first two (2) visits to a Specialty Care Provider within a ninety-day (90-day) period for certain health care services. All subsequent visits require Pre-Authorization.

Retiree means an individual who was a covered Employee immediately prior to the date of retirement and who, upon retirement, satisfied one (1) of the following categories:

1. Immediately received retirement benefits from an approved state or governmental agency defined benefit plan.
2. Was not eligible for participation in such plan or legally opted not to participate in such plan; and either:
    a. Began employment prior to September 15, 1979, has 10 years of continuous state service, and has reached the age of 65; or
    b. Began employment after September 16, 1979, has 10 years of continuous state service, and has reached the age of 70; or
    c. Was employed after July 8, 1992, has 10 years of continuous state service, has a credit for a minimum of 40 quarters in the Social Security system at the time of employment, and has reached the age of 65; or
    d. Maintained continuous coverage with the Program as an eligible Dependent until he/she became eligible as a former state Employee to receive a retirement benefit from an approved state governmental agency defined benefit plan.
3. Immediately received retirement benefits from a state-approved or state governmental agency-approved defined contribution plan and has accumulated the total number of years of creditable service which would have entitled him/her to receive a retirement allowance from the defined benefit plan of the retirement system for which the Employee would have otherwise been eligible. The appropriate state governmental agency or retirement system responsible for administration of the defined contribution plan is responsible for certification of eligibility to the Office of Group Benefits.
4. Retiree also means an individual who was a covered Employee and continued the coverage through the provisions of COBRA immediately prior to the date of retirement and who, upon retirement, qualified for any of items 1, 2, or 3 above.

Skilled Nursing Facility means an institution or distinct part of an institution that:

1. Is operated in accordance with the applicable laws of the jurisdiction in which it is located to provide skilled nursing care for sick and injured people; and
2. Provides 24-hour-a-day nursing services under the supervision of a licensed Physician or registered nurse, who is devoted full-time to such supervision; and
3. Maintains clinical records of each patient; and
4. Has appropriate methods and procedures to administer Drugs to patients; and
5. Is not an institution, or part of an institution, that is:
    a. A Hospital; or
    b. Primarily for the care of mental Illness, Drug addiction, alcoholism, or tuberculosis; or
    c. Primarily engaged in providing domiciliary care, Custodial Care, educational care, or care for the aged.

Special Enrollment Period is the thirty (30) days after an Employee has other coverage terminated due to: a) loss of eligibility as a result of separation, divorce, death or termination of employment, b) reduction in the number of hours worked, c) COBRA coverage which is exhausted or d) loss of coverage because contributions were terminated, in which case an Employee may enroll in this Plan.

Specialty Care Provider is a medical or surgical Physician other than those defined as Medical Home Primary Care Physicians.

Specialty Drugs include high cost drugs and pharmaceuticals produced through DNA technology or biological processes that target Chronic or complex disease states and require unique handling, distribution, or administration as well as a customized medical management program for successful use.

Speech Therapy means a healthcare service to evaluate, treat, and diagnose, speech, language, and cognitive-communication and swallowing disorders in individuals of all ages from infants to the elderly.

Supplementary Benefits are additional benefits above and beyond the basic health benefits.

Tier I Cost Share means the Co-payments and Co-insurance referred to in the "Tier I In-Network" column in Section IV of this Certificate of Coverage and/or shown in the Cost Share Schedule.

Tier II Co-insurance means the co-insurance the Member must pay in addition to the Member's Tier I Cost Share. Tier II Co-insurance is based on the Vantage Allowable and applies before the Tier I Cost Share.

Tier I Provider or Tier I - Most Participating Providers are Tier I Providers. Members seeing Tier I Providers pay only the Co-payments and Co-insurance listed in this Certificate of Coverage and/or shown in the Cost Share Schedule (Tier I Cost Share).

Tier II Provider or Tier II - Participating Providers whose cost may be higher than other similar Participating Providers. Members who choose to see these providers will have to pay an additional co-insurance (Tier II Co-insurance) in addition to their standard Co-payments and Co-insurance as listed in this Certificate of Coverage and/or shown in the Cost Share Schedule (Tier I Cost Share).

Urgent Care Center means a Physician's office or clinic or other facility primarily engaged in treating patients whose conditions require immediate medical attention. The term Urgent Care Center does not include Hospital emergency department or other outpatient emergency department or other outpatient Hospital facility.

Utilization Review/Quality Management (UR/QM) means a function performed by Vantage or its designee to review and approve or deny authorization or payment for Covered Services as to the Medical Necessity and quality of the care and compliance with agreed-upon policies, procedures and protocols established by Vantage's Board of Directors.

Vantage Allowable means the amount Vantage would pay to a Participating Provider for the Covered Service or the amount set forth in the Vantage Non-Participating Provider fee schedule, as determined by Vantage.

Vantage Service Area means the geographic area served by Vantage as approved by the Louisiana Department of Insurance, which may be limited to certain geographic regions and defined by OGB for purposes of eligibility and enrollment in this Plan.

Waiting Period is defined as the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the Plan.

SECTION IV: SCHEDULE OF COVERED SERVICES & BENEFITS

Coverage will be provided for the Covered Services listed. Covered Services are the Medically Necessary services and supplies, including Prescription Drugs, received upon the recommendation and approval of a Physician and required for the treatment of a Member, subject to the health care benefit offered by OGB to Employees as part of a Group Health Plan under an agreement with Vantage and subject to the exclusions and limitations listed elsewhere in the Certificate of Coverage.

The Benefit Level is usually determined by the provider's network status. However, the Benefit Level for services cannot be better than the network status of the ordering Physician for outpatient services and the admitting Physician for inpatient services.

Covered Services are subject to the Co-insurance, Co-payments, and Out-of-Network Deductible shown in the Cost Share Schedule and/or in this Section IV. Co-insurance, Co-payments, and the Out-of-Network Deductible are a Member's responsibility and may be due at the time services are rendered. Co-insurance is applied before Co-payments.

The Out-of-Pocket Maximum dollar amounts specified below will limit the amount a Member will pay out-of-pocket for Tier I Benefit Level Eligible Charges each Benefit Period subject to the exclusions and limitations listed below.

Tier I In-Network Eligible Charges

► ***Deductible***

There is no Deductible for Tier I Benefit Level Eligible Charges.

► ***Out-of-Pocket Maximum***

For single-coverage individual policy Members (Members with no Dependents):

The individual policy Out-of-Pocket Maximum for Tier I Benefit Level Eligible Charges is two thousand dollars ($2,000.00). After a Member's share of Tier I Benefit Level Eligible Charges to be paid during a Benefit Period equals two thousand dollars ($2,000.00), the Plan will pay Tier I Benefit Level Eligible Charges for the Member at 100% of the Vantage Allowable for the remainder of the Benefit Period subject to the exclusions and limitations listed below.

For family-coverage policy Members (Members with one or more Dependents):

The family policy Out-of-Pocket Maximum for Tier I Benefit Level Eligibles Charges is six thousand dollars ($6,000.00). After a Member's and his or her Dependents' shares of Tier I In-Benefit Level Eligible Charges to be paid during a Benefit Period equals six thousand dollars ($6,000.00), the Plan will pay Tier I Benefit Level Eligible Charges for the Member and his or her Dependents at 100% of the Vantage Allowable for the remainder of the Benefit Period subject to the exclusions and limitations listed below. The family Out-of-Pocket Maximum is cumulative, which means it can be met by one or more family Members.

Exclusions and limitations for Tier I In-Network Out-of-Pocket Maximum

Charges incurred by a Member or any Dependent for the following will NOT be applied to the Tier I In-Network Out-of-Pocket Maximum:

i. Services performed by Tier II In-Network Providers
ii. Services performed by Out-of-Network Providers (except for Emergency Medical Services)
iii. Out-of-Network Deductible
iv. Office Visit Co-payments
v. Urgent Care Services Co-payments
vi. Durable Medical Equipment and Supplies Co-insurance
vii. Extended Care Facility Co-payments
viii. Certain Other Covered Services

ix. Supplementary Benefits Co-insurance
x. Outpatient Mental Health Services Co-payments
xi. Outpatient Alcohol and Chemical Dependency Co-payments
xii. Approved Transplant Services Co-payments and Co-insurance
xiii. Prescription Drug Co-payments and Co-insurance
xiv. Charges in excess of the maximum benefit available
xv. Charges that are not Eligible Charges
xvi. Charges above the Vantage Allowable for Covered Services performed by Out-of-Network Providers
xvii. Monthly premium payments

Tier II In-Network Eligible Charges

► ***Deductible***

There is no Deductible for Tier II Benefit Level Eligible Charges.

► ***Out-of-Pocket Maximum***

There is no Tier II Out-of-Pocket Maximum for Tier II Benefit Level Eligible Charges.

Out-of-Network Eligible Charges

► ***Deductible***

The Deductible dollar amounts specified below are the amounts that the Member must pay each Benefit Period before Out-of-Network benefits are payable under the Plan.

The Deductible applies to Out-of-Network Eligible Charges to be paid by a Member(s) during the Benefit Period. The family Deductible is cumulative, which means it can be met by one or more family Members. Charges above the Vantage Allowable to be paid by a Member for Eligible Charges provided by Out-of-Network Providers do not apply toward the Deductible.

All Out-of-Network Eligible Charges are subject to the Deductible.

For single-coverage individual policy Members (Members with no Dependents):

The individual policy Deductible for Out-of-Network Benefit Level Eligible Charges is one thousand dollars ($1,000.00). After a Member's Out-of-Network Benefit Level Eligible Charges to be paid during a Benefit Period equals one thousand dollars ($1,000.00), the Plan will pay Out-of-Network Benefit Level Eligible Charges for the Member at fifty percent (50%) of the Vantage Allowable.

For family-coverage policy Members (Members with one or more Dependents):

The family policy Deductible for Out-of-Network Benefit Level Eligible Charges is three thousand dollars ($3,000.00). After a Member's and his or her Dependents' Out-of-Network Benefit Level Eligible Charges to be paid during a Benefit Period equals three thousand dollars ($3,000.00), the Plan will pay Out-of-Network Benefit Level Eligible Charges for the Member at fifty percent (50%) of the Vantage The family Deductible is cumulative, which means it can be met by one or more family Members.

► ***Out-of-Pocket Maximum***

There is no Out-of-Network Out-of-Pocket Maximum for Out-of-Network Benefit Level Eligible Charges.

The Tier I In-Network benefits that appear on the following pages:

- **Must be arranged by your PCP.**
- **Reflect the coverage provided by Tier I Providers. If the Covered Service is performed by a Tier II Provider, the Member will pay the Tier II Co-insurance in addition to the Tier I Cost Share.**

The same Covered Services which require Pre-Authorization for Tier I Providers also require Pre-Authorization for Tier II Providers.

Certain benefits require that care must be received from Participating Providers and arranged by your PCP. Such benefits are included in this section and are listed as "No Out-of-Network coverage" in the "Out-of-Network" column or in the heading of the entire section.

If you receive services from an Out-of-Network Provider, the charges may be significantly more than an In-Network Provider's fees and/or the Vantage Allowable. You may be balance billed by the Out-of-Network Provider for the cost of services exceeding the Vantage Allowable. In-Network Providers cannot balance bill Members. Charges above the Vantage Allowable for Covered Services provided by Out-of-Network Providers do not apply toward the Out-of-Network Deductible.

All Covered Services performed by Out-of-Network Providers are subject to the Deductible.

All Covered Services except Emergency Medical Services performed by Out-of-Network Providers require Pre-Authorization.

Specialty Drugs must be provided by the Plan's contracted specialty pharmacy. When Specialty Drugs are not provided by the Plan's contracted specialty pharmacy, regardless of place of service (e.g., inpatient, outpatient, Physician's office, etc.), Pre-Authorization is required and the Plan's payment is limited to what the Plan would have paid its specialty pharmacy less the Member's cost share.

Please refer to the following important information concerning Co-insurance, Co-payments, the Out-of-Network Deductible, and Out-of-Pocket Maximum when reviewing this section.

- Covered Services are subject to the Co-insurance, Co-payments, Out-of-Network Deductible and maximums shown in the attached Cost Share Schedule and this section.
- Co-insurance, Co-payments and Out-of-Network Deductible are a Member's responsibility and may be due at the time services are rendered.
- Member Cost Share amounts are applied in the following order: 1) Tier II Co-insurance, if applicable, 2) Co-insurance, 3) Co-payments, and 4) Out-of-Network Deductible.
- Certain Co-payments and Co-insurance amounts do not apply to the Out-of-Pocket Maximums and are noted in the applicable benefits in this section.

Physician Office Services

Physician office services are Medically Necessary services for the treatment of Accidental Bodily Injury, Illness, injury or disease that are rendered in the Physician's office.

COVERED SERVICE	TIER I IN-NETWORK COVERAGE	OUT-OF-NETWORK* (SUBJECT TO OUT-OF-NETWORK DEDUCTIBLE)
Medical Home Primary Care Physician ("MH-PCP") Office Visits: Family practice, general practice, general pediatrician and general internal medicine Physician office visits.	100% Coverage of Vantage Allowable less **$15.00** Primary Care Physician office visit Co-payment. **Not included in the Out-of-Pocket Maximum.**	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
Specialty Care Provider Office Visits: ► Medical or surgical Physician other than those defined as Medical Home Primary Care Physicians. **Requires Referral (except OB/GYN)**. ► Routine Vision Exam: One (1) every Benefit Period. No Referral required.	100% Coverage of Vantage Allowable less **$45.00** Specialty Care office visit Co-payment. **Not included in the Out-of-Pocket Maximum.**	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
Office Diagnostic Services: Lab and x-ray services performed in the Physician office. ► Lab ► X-ray and other office diagnostic services, excluding major diagnostic tests.	100% Coverage of Vantage Allowable. 100% Coverage of Vantage Allowable.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. 50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
Maternity-related Services: Eligible Charges related to the pregnancy diagnosis.	100% Coverage of Vantage Allowable less **$90.00** maternity office visit Co-payment on initial visit only. **Not included in the Out-of-Pocket Maximum.**	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.

* When you seek treatment from an Out-of-Network Provider, the charges may be more than the Vantage Allowable. The Out-of-Network Provider may balance bill you for any charges over the Vantage Allowable. In-Network Providers cannot balance bill Members. All services performed by Out-of-Network Providers require Pre-Authorization.

Wellness & Preventive Care

Wellness and preventive care services include health evaluation for the prevention and early detection of Illness, injury or disease provided or arranged by your MH-PCP.

PPACA Wellness & Preventive Care Services

Vantage wellness and preventive care services shall be Covered Services in accordance with the Patient Protection and Affordable Care Act (PPACA or Affordable Care Act) and all rules and regulations issued thereunder. These services shall be provided by In-Network Providers without cost-sharing (i.e., Co-payments) will not apply to wellness and preventive care In-Network Covered Services).

COVERED SERVICE	IN-NETWORK COVERAGE	OUT-OF-NETWORK* (SUBJECT TO OUT-OF-NETWORK DEDUCTIBLE)
Annual Examination: ► One (1) routine physical exam per Member per Benefit Period. ► Routine lab services performed as part of the routine physical exam: CBC, CMP, TSH, Lipid Panel, colorectal cancer screening (fecal occult blood test) and UA.	100% Coverage of Vantage Allowable.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
Women's Health: ► **Bone Density:** ▪ One (1) bone density screening after age 50. No Pre-Authorization required.	100% Coverage of Vantage Allowable.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
▪ All other bone density tests are limited to one (1) test every twenty-four (24) months and require Pre-Authorization.	100% Coverage of Vantage Allowable.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
► **Breastfeeding:** Comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women. Maximum benefit of $100 for breastfeeding equipment and supplies.	100% Coverage of Vantage Allowable.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
► **Contraception:** Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs.	100% Coverage of Vantage Allowable.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
► **Domestic and interpersonal violence:** Screening and counseling for all women.	100% Coverage of Vantage Allowable.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.

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Wellness & Preventive Care (continued)

COVERED SERVICE	IN-NETWORK COVERAGE	OUT-OF-NETWORK* (SUBJECT TO OUT-OF-NETWORK DEDUCTIBLE)
Women's Health: (continued)		
► **Gestational diabetes:** Screening for women twenty-four (24) to twenty-eight (28) weeks pregnant and those at high risk of developing gestational diabetes.	100% Coverage of Vantage Allowable.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
► **Human Immunodeficiency Virus (HIV):** Screening and counseling for sexually active women.	100% Coverage of Vantage Allowable.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
► **Human Papillomavirus (HPV) DNA Test:** High risk HPV DNA testing every three (3) years for women with normal cytology results who are thirty (30) years of age or older.	100% Coverage of Vantage Allowable.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
► **Lab and counseling** relating to pregnancy (including Dependent pregnancies), including single assay; syphilis test; and CBC.	100% Coverage of Vantage Allowable.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
► **Routine Pelvic Examination:** Routine pelvic examination with one (1) routine Pap test per Member per Benefit Period.	100% Coverage of Vantage Allowable.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
► **Screening Mammogram:** ▪ One (1) baseline mammogram for any woman who is 35-39 years of age. ▪ One (1) mammogram every twenty-four (24) months for any woman who is 40-49 years of age or more frequently if recommended by her Physician. ▪ One (1) mammogram every twelve (12) months for any woman who is 50 years of age or older.	100% Coverage of Vantage Allowable.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
► **Sexually Transmitted Infections (STI):** Counseling for sexually active women.	100% Coverage of Vantage Allowable.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.

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Wellness & Preventive Care (continued)

COVERED SERVICE	IN-NETWORK COVERAGE	OUT-OF-NETWORK* (SUBJECT TO OUT-OF-NETWORK DEDUCTIBLE)
Men's Health: ► Routine prostate test (PSA) per Member per Benefit Period.	100% Coverage of Vantage Allowable.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
► Abdominal aortic aneurysm screening. One-time screening, by ultrasonography, for men ages 65-75 who have ever smoked.	100% Coverage of Vantage Allowable.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
Children's Health: ► Five (5) visits per Member per Benefit Period for age 0-12 months. ► Three (3) visits per Member per Benefit Period for 13 to 24 months of age. ► One(1) routine physical exam per Member per Benefit Period for 24 months of age through age 18.	100% Coverage of Vantage Allowable.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
Immunizations & Vaccines	100% Coverage of Vantage Allowable.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
Vantage Wellness Program: Vantage offer the following four (4) wellness incentive programs: ► Health Maintenance; ► Tobacco Cessation; ► Weight Loss; ► Combination Weight Loss and Tobacco Cessation.	100% Coverage of Vantage Allowable.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.

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Inpatient Hospital Services

Providers' services which are Medically Necessary for the treatment of Accidental Bodily Injury, Illness, injury or disease rendered while admitted as an inpatient to a facility. Perioperative services rendered by a Registered Nurse First Assistant will be covered if the same service would be covered when rendered by a Physician.

COVERED SERVICE	TIER I IN-NETWORK COVERAGE	OUT-OF-NETWORK* (SUBJECT TO OUT-OF-NETWORK DEDUCTIBLE)
Inpatient Semi-Private Room: Including Intensive Care Units (ICU) and Cardiac Care Units (CCU).  **Requires Pre-Authorization**.	100% Coverage of Vantage Allowable less **$150.00** inpatient Co-payment per day up to **$450.00** maximum per admission.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
Physician Services: Surgery and in-hospital visits.	100% Coverage of Vantage Allowable.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.

Outpatient Observation Services

COVERED SERVICE	TIER I IN-NETWORK COVERAGE	OUT-OF-NETWORK* (SUBJECT TO OUT-OF-NETWORK DEDUCTIBLE)
Observation Stay:  **Requires Pre-Authorization**.	100% Coverage of Vantage Allowable less **$150.00** inpatient Co-payment per day up to **$450.00** maximum per stay.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
Physician Services:	100% Coverage of Vantage Allowable.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.

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Ambulatory Surgery Unit (ASU) or Outpatient Surgery

Providers' services which are Medically Necessary for the treatment of Accidental Bodily Injury or Illness, injury or disease rendered in a Hospital or a free-standing surgical facility, whether affiliated with a Physician's office or not.

COVERED SERVICE	TIER I IN-NETWORK COVERAGE	OUT-OF-NETWORK* (SUBJECT TO OUT-OF-NETWORK DEDUCTIBLE)
Ambulatory Surgery Unit (ASU) or Outpatient Surgery:  **Requires Pre-Authorization**.	100% Coverage of Vantage Allowable less **$150.00** applicable ASU/outpatient surgery Co-payment.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.

Urgent Care Services

Providers' services which are rendered at a Physician's office or clinic or other facility primarily engaged in treating patients whose conditions require immediate medical attention. Urgent Care Centers do not include Hospital emergency departments or other outpatient emergency departments or other outpatient hospital facility.

COVERED SERVICE	TIER I IN-NETWORK	OUT-OF-NETWORK* (SUBJECT TO OUT-OF-NETWORK DEDUCTIBLE)
Urgent Care Services:  **Follow-up visits require Pre-Authorization**.	100% Coverage of Vantage Allowable less **$45.00** Specialty Care office visit Co-payment. **Not included in Out-of-Pocket Maximum.**	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.

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Outpatient Hospital Services

COVERED SERVICE	TIER I IN-NETWORK COVERAGE	OUT-OF-NETWORK* (SUBJECT TO OUT-OF-NETWORK DEDUCTIBLE)
Major Diagnostic Testing: ► Bone scan ► Cardiac stress test ► CAT scan ► Echocardiogram ► EEG ► EMG ► Event monitor ► HIDA scan ► Holter monitor ► MRI ► Nerve conduction study ► Nuclear cardiac stress test ► Nuclear medicine test ► PET scan ► Pulmonary function test ► Sleep study  **Requires Pre-Authorization**.	100% Coverage of Vantage Allowable less **$150.00** major diagnostic Co-payment per test, whether the test is performed in an office or outpatient setting.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
Sonograms/Ultrasounds  **Requires Pre-Authorization**.	100% Coverage of Vantage Allowable less **$150.00** sonogram/ultrasound Co-payment per test.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
Other Hospital Outpatient Services:		
► Diagnostic tests, x-rays, and other Hospital outpatient services not listed elsewhere in this Section IV and not performed in an office visit setting.	Member pays 100% Co-insurance of Vantage Allowable up to **$150.00** daily maximum Cost Share for Hospital outpatient services.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
► Lab services.	100% Coverage of Vantage Allowable.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.

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Emergency Medical Services

Emergency Medical Services are those medical services necessary to screen, evaluate, and stabilize an Emergency Medical Condition. Coverage is available for Accidental Bodily Injury or sudden onset of an acute Illness (see Emergency criteria below). **Return visits** to the Emergency facility for follow-up care are **not covered**. If Emergency Medical Services are provided by Tier II Providers, the Tier II Co-insurance applies.

Emergency criteria:

- Severe pain or the sudden onset of pain. Examples include: chest pain, headache with neurological changes or acute severe abdominal pain.
- Severe hemorrhage or bleeding
- Respiratory distress
- Accidental Bodily Injuries. Examples include: 2nd & 3rd degree burns, lacerations requiring sutures, or bone fractures.
- Obvious severe emotional distress requiring treatment with IM or IV Drugs
- Unconsciousness
- Convulsions

COVERED SERVICE	VANTAGE COVERAGE	OUT-OF-NETWORK* (SUBJECT TO OUT-OF-NETWORK DEDUCTIBLE)
Emergency Room Service and Supplies: ► If treated and released within 24 hours of onset of Illness or injury.	100% Coverage less **$100.00** emergency room Co-payment for each visit.	100% Coverage less **$100.00** emergency room Co-payment for each visit.
► If admitted within 24 hours subsequent to treatment.	100% Coverage. Emergency room Co-payment waived if admitted.	100% Coverage. Emergency room Co-payment waived if admitted.
Ambulance Service: Ambulance service provided by a professional ambulance service for local ground transportation to a Hospital for a covered medical emergency. Air ambulance covered at the discretion of Vantage. The maximum benefit for ground ambulance services is **$350.00** per day. The maximum benefit for air ambulance services is **$1,500.00** per day.	100% Coverage of Vantage Allowable less **$50.00** Co-payment for ground ambulance or **$250.00** Co-payment for air ambulance.	100% Coverage of Vantage Allowable less **$50.00** Co-payment for ground ambulance or **$250.00** Co-payment for air ambulance.
Ambulance Transfers: Ambulance transfers by a professional ambulance service from an Out-of-Network Provider Hospital to an In-Network Provider Hospital or from a Hospital to other medical facility or home if Medically Necessary. **Requires Pre-Authorization**.	100% Coverage of Vantage Allowable.	100% Coverage of Vantage Allowable.

Durable Medical Equipment and Supplies

Durable Medical Equipment (DME) are items that serve a medical purpose only and are Medically Necessary for the treatment of Illness or injury, and can withstand long-term repeated use, and are appropriate for home use. **Lifetime maximum of $50,000 applies to DME, excluding prosthetics.**

All DME and supplies require Pre-Authorization. **Lifetime maximum of $50,000 applies, excluding Prosthetic Devices and Prostheses. Annual maximum of $50,000 per limb applies to Prosthetic Devices and Prostheses. Supplies must be Medically Necessary and provided by or under the direction of a Physician outside of a Hospital, Skilled Nursing Facility (SNF), or other Vantage approved health care facility**. **Replacement of an item *previously* furnished will be solely at Vantage's option**.

DME Co-insurance does not apply to the Tier I Out-of-Pocket Maximum.

COVERED SERVICE	TIER I IN-NETWORK COVERAGE	OUT-OF-NETWORK* (SUBJECT TO OUT-OF-NETWORK DEDUCTIBLE)
Durable Medical Equipment and Supplies: As defined in "Definitions" (Section III) **Requires Pre-Authorization.**	80% Coverage of Vantage Allowable. Member pays 20% of Vantage Allowable. **Not included in the Out-of-Pocket Maximum.**	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
Hearing Aid for Minor Member: Member must be under the age of eighteen (18). The hearing aid must be fitted and dispensed by a Participating licensed audiologist or hearing aid specialist following a medical clearance by a Participating Physician and an audiological evaluation medically appropriate to the age of the minor Member. A maximum benefit shall apply of $1,400 per hearing aid for each impaired ear not to exceed one every thirty-six (36) months. **Requires Pre-Authorization**.	80% Coverage of Vantage Allowable. Member pays 20% of Vantage Allowable. **Not included in the Out-of-Pocket Maximum.**	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
Insulin Pump, Training, and Supplies: This benefit is limited to one pump per Member per lifetime. No replacements are covered. Medical Necessity criteria must be met. **Requires Pre-Authorization.** Training, supplies and other services specific to an insulin pump are covered. **Requires Pre-Authorization.**	80% Coverage of Vantage Allowable. Member pays 20% of Vantage Allowable. **Not included in the Out-of-Pocket Maximum.** 80% Coverage of Vantage Allowable. Member pays 20% of Vantage Allowable. **Not included in the Out-of-Pocket Maximum.**	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. 50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.

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Durable Medical Equipment and Supplies (continued)

COVERED SERVICE	TIER I IN-NETWORK COVERAGE	OUT-OF-NETWORK* (SUBJECT TO OUT-OF-NETWORK DEDUCTIBLE)
Oxygen and rental of equipment for its administration. **Requires Pre-Authorization**.	80% Coverage of Vantage Allowable. Member pays 20% of Vantage Allowable. **Not included in the Out-of-Pocket Maximum.**	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
Prosthetic Devices and Prosthetic Services: Artificial limbs, braces and appliances to replace physical organs or parts that are not surgically implanted. Must be designed to aid or maximize function, stability, and safety. Prosthetic Device or Prosthesis must be Medically Necessary as a result of injury or Illness, and is limited to the initial issue of such appliance. An annual benefit maximum of $50,000 per limb applies. **Requires Pre-Authorization**.	80% Coverage of Vantage Allowable. Member pays 20% of Vantage Allowable. **Not included in the Out-of-Pocket Maximum.**	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
Rental, not to exceed purchase price, of: ► Wheelchair, crutches, canes or walkers ► Hospital bed ► Home ventilation equipment for treatment of chronic and acute respiratory failure. **Requires Pre-Authorization**.	80% Coverage of Vantage Allowable. Member pays 20% of Vantage Allowable. **Not included in the Out-of-Pocket Maximum.**	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.

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Extended Care Facilities

 **All Covered Services in this subsection require Pre-Authorization**.

COVERED SERVICE	TIER I IN-NETWORK COVERAGE	OUT-OF-NETWORK* (SUBJECT TO OUT-OF-NETWORK DEDUCTIBLE)
Long-Term Acute Care Facility (post-acute Illness or injury): Semi-private room and board and Medically Necessary services. Benefit limit of sixty (60) days per Benefit Period for Long-Term Acute Care, Rehabilitation Facility and Skilled Nursing Facility combined. **Requires Pre-Authorization.**	100% Coverage of Vantage Allowable less **$50.00** extended care facility Co-payment per day. **Not included in the Out-of-Pocket Maximum.**	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
Rehabilitation Facility (post-acute Illness or injury, non-custodial): Semi-private room and board and Medically Necessary services. Benefit limit of sixty (60) days per Benefit Period for Long-Term Acute Care, Rehabilitation Facility and Skilled Nursing Facility combined. **Requires Pre-Authorization**.	100% Coverage of Vantage Allowable less **$50.00** extended care facility Co-payment per day. **Not included in the Out-of-Pocket Maximum.**	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
Skilled Nursing Facility (post-Hospital, non-custodial): Semi-private room and board and Medically Necessary services. Benefit limit of sixty (60) days per Benefit Period for Long-Term Acute Care, Rehabilitation Facility and Skilled Nursing Facility combined. **Requires Pre-Authorization**.	100% Coverage of Vantage Allowable less **$50.00** extended care facility Co-payment per day. **Not included in the Out-of-Pocket Maximum.**	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.

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Other Covered Services

All Covered Services in this subsection require Pre-Authorization.

COVERED SERVICE	TIER I IN-NETWORK COVERAGE	OUT-OF-NETWORK* (SUBJECT TO OUT-OF-NETWORK DEDUCTIBLE)
Accidental Dental: Repair to sound and natural teeth damaged or injured (See "Definitions" Section III for *Accident* and *Accidental Bodily Injury*). Dental implants are not covered. Extractions of wisdom teeth are not covered. **Requires Pre-Authorization. Follow-up visits require Pre-Authorization**.	80% Coverage of Vantage Allowable. Member pays 20% of Vantage Allowable.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
Allergenic Testing: Diagnostic testing and immuno-therapy. **Requires Pre-Authorization**.	80% Coverage of Vantage Allowable. Member pays 20% of Vantage Allowable. **Not included in the Out-of-Pocket Maximum.**	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
Anesthesia and Hospitalization for Dental Procedures: Only applies when the mental or physical condition of the insured requires dental treatment to be rendered in a Hospital setting. Coverage does not apply to treatment rendered for temporal mandibular joint (TMJ) disorders. **Requires Pre-Authorization.**	100% Coverage of Vantage Allowable less **$150.00** inpatient Co-payment per day up to **$450.00** maximum per stay or **$150.00** outpatient surgery Co-payment.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
Attention Deficit/Hyperactivity Disorder: Diagnosis and treatment of attention deficit/hyperactivity disorder. **Requires Pre-Authorization.**	**Office Visits:** 100% Coverage of Vantage Allowable less **$15.00** Primary Care Physician office visit Co-payment or **$45.00** Specialty Care office visit Co-payment. **Not included in the Out-of-Pocket Maximum.** **Other Services:** 80% Coverage of Vantage Allowable. Member pays 20% of Vantage Allowable. **Not included in the Out-of-Pocket Maximum.**	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. 50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.

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Other Covered Services (continued)

COVERED SERVICE	TIER I IN-NETWORK COVERAGE	OUT-OF-NETWORK* (SUBJECT TO OUT-OF-NETWORK DEDUCTIBLE)
Autism Spectrum Disorders: Member must be under the age of seventeen (17). Includes coverage for diagnosis and treatment for Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, and any other pervasive Developmental Disorder defined in the most recent edition of the Diagnostic and Statistical Manual of mental Disorders (DSM). Treatment by providers that includes Applied Behavior Analysis must be certified by the Behavior Analyst Certification Board or provide documented evidence of equivalent education, professional training, and supervised experience. The maximum benefit for all Autism Spectrum Disorder Covered Services for each Member shall be $36,000.00 per Benefit Period. **Requires Pre-Authorization**.	80% Coverage of Vantage Allowable. Member pays 20% of Vantage Allowable. **Not included in the Out-of-Pocket Maximum.**	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
Cardiac Rehabilitation: Maximum of thirty-six (36) visits per Benefit Period for first episode following services provided for myocardial infarction, coronary artery bypass surgery, or stable angina pectoris, per Benefit Period (once in a lifetime per diagnosis). Twelve (12) visits for subsequent episodes. **Requires Pre-Authorization.**	100% Coverage of Vantage Allowable less **$45.00** Specialty Care Co-payment. **Not included in the Out-of-Pocket Maximum.**	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
Chemotherapy/Radiation Therapy: **Requires Pre-Authorization.**	80% Coverage of Vantage Allowable. Member pays 20% of Vantage Allowable.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.

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Other Covered Services (continued)

COVERED SERVICE	TIER I IN-NETWORK COVERAGE	OUT-OF-NETWORK* (SUBJECT TO OUT-OF-NETWORK DEDUCTIBLE)
Cleft Lip and Cleft Palate: Treatment and correction of cleft lip and cleft palate includes coverage for secondary conditions and treatment attributable to primary diagnosis of cleft lip/cleft palate including: ► Oral/facial surgery, management and follow-up ► Prosthetic devices ► Orthodontic treatment and management ► Preventive/restorative dentistry associated with prosthetic and/or orthodontic treatment ► Speech-language evaluation/therapy ► Audiological assessments and amplification devices ► Otolaryngology treatment ► Psychological assessment and counseling ► Genetic assessment and counseling for patient and parents	**Office Visits:** 100% Coverage of Vantage Allowable less **$15.00** Primary Care Physician office visit Co-payment or **$45.00** Specialty Care office visit Co-payment. **Not included in the Out-of-Pocket Maximum.** **Surgery:** 100% Coverage of Vantage Allowable less **$150.00** outpatient surgery Co-payment. **Other Services:** 80% Coverage of Vantage Allowable. Member pays 20% of Vantage Allowable. **Not included in the Out-of-Pocket Maximum.**	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Deductible. 50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. 50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
Diabetes Management: Outpatient self-management training (including the initial equipment and supplies) and education/medical nutrition therapy for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes if prescribed by the primary attending Physician. Such outpatient training and nutrition therapy programs shall be provided by a health care professional in compliance with the National Standards for Diabetes Self-Management Education Program, as developed by the American Diabetes Association. The outpatient training and nutrition therapy program benefit shall not exceed $500.00. Additional training may be covered based on Medical Necessity. **Requires Pre-Authorization**.	100% Coverage of Vantage Allowable less **$15.00** Primary Care Physician office visit Co-payment.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
Dialysis: Treatment must be obtained from a certified Dialysis Treatment Center. Treatments covered may include hemodialysis, peritoneal dialysis and hemofiltration. **Requires Pre-Authorization**.	100% Coverage of Vantage Allowable.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.

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Other Covered Services (continued)

COVERED SERVICE	TIER I IN-NETWORK COVERAGE	OUT-OF-NETWORK* (SUBJECT TO OUT-OF-NETWORK DEDUCTIBLE)
Home Health Care (non-custodial): Furnished in Member's home by a Participating home health agency. Maximum of 150 days per Benefit Period. **Requires Pre-Authorization**.	100% Coverage of Vantage Allowable.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
Hospice Care: Medically Necessary services and supplies of Participating Provider. **Requires Pre-Authorization**.	100% Coverage of Vantage Allowable.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
Interpreter for the Hearing Impaired: Includes coverage for expenses incurred by any hearing impaired Member for services performed by a qualified interpreter/ transliterator, other than a family member of the Member, when such services are used by the Member in connection with medical treatment or diagnostic consultations performed by a Health Care Provider. **Requires Pre-Authorization**.	80% Coverage of Vantage Allowable. Member pays 20% of Vantage Allowable.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
Low Protein Foods for Treatment of Inherited Metabolic Diseases: Low protein foods, defined as less than one gram of protein per serving, that are intended to be used under the direction of a Physician for the Medically Necessary dietary treatment of the following inherited metabolic diseases: ► Glutaric Acidemia, ► Isovaleric Acidemia (IVA), ► Maple Syrup Urine Disease, ► Methylmalonic Acidemia (MMA), ► Phenylketonuria (PKU), ► Propionic Acidemia, ► Tyrosinemia and ► Urea Cycle Defects Vantage must approve the food source prior to coverage. Benefit maximum of $200.00 per month. **Requires Pre-Authorization**.	80% Coverage of Vantage Allowable. Member pays 20% of Vantage Allowable. **Not included in the Out-of-Pocket Maximum.**	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.

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Other Covered Services (continued)

COVERED SERVICE	TIER I IN-NETWORK COVERAGE	OUT-OF-NETWORK* (SUBJECT TO OUT-OF-NETWORK DEDUCTIBLE)
Nutritional Counseling: Maximum of four (4) visits per Benefit Period. **Requires Pre-Authorization.**	100% Coverage of Vantage Allowable less **$15.00** Primary Care Physician office visit Co-payment.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
Occupational and Speech Therapy: Services after Illness or injury to restore pre-existing function. Not covered for Chronic or Developmental Conditions. Services must be obtained from a licensed occupational or speech therapist, other than an individual who resides in the Member's home or who is a family member. Maximum combined total of twenty (20) visits per Benefit Period. **Requires Pre-Authorization.**	80% Coverage of Vantage Allowable. Member pays 20% of Vantage Allowable. **Not included in the Out-of-Pocket Maximum.**	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
Physical Therapy: Services provided by a licensed physical therapist other than an individual who resides in the Member's home or who is a family member. Maximum of twenty (20) visits per Benefit Period. Not covered for Chronic or Recurrent Conditions. (Example: Fibromyalgia and muscle tension headaches). **Requires Pre-Authorization.**	80% Coverage of Vantage Allowable. Member pays 20% of Vantage Allowable. **Not included in the Out-of-Pocket Maximum.**	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
Spinal Manipulation and Spinal Adjustment: Treatment of dislocation, subluxation or misplacement of vertebrae and/or strains and sprains of soft tissues related to the spine provided by a Health Care Provider. **Requires Pre-Authorization.**	100% Coverage of Vantage Allowable less **$15.00** Primary Care Physician office visit Co-payment or **$45.00** Specialty Care office visit Co-payment. **Not included in the Out-of-Pocket Maximum.**	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.[5]

* When you seek treatment from an Out-of-Network Provider, the charges may be more than the Vantage Allowable. The Out-of-Network Provider may balance bill you for any charges over the Vantage Allowable. In-Network Providers cannot balance bill Members. All services performed by Out-of-Network Providers require Pre-Authorization.

Supplementary Benefits

COVERED SERVICE	TIER I IN-NETWORK COVERAGE
Alcohol & Drug Related Injuries: Treatment for injuries sustained while under the influence of alcohol or the illegal use of Drugs.  **Requires Pre-Authorization.**	60% Coverage of Vantage Allowable. Member pays 40% of Vantage Allowable. **Not included in the Out-of-Pocket Maximum.**
Breast Reduction: Medical Necessity criteria must be met.  **Requires Pre-Authorization**.	60% Coverage of Vantage Allowable. Member pays 40% of Vantage Allowable. **Not included in the Out-of-Pocket Maximum.**
Cochlear Implant: This benefit is limited to one unilateral cochlear implant per Member per lifetime. No replacements are covered. Medical Necessity criteria must be met. Training and other services specific to the cochlear implant will be covered at 60%.  **Requires Pre-Authorization**.	60% Coverage of Vantage Allowable. Member pays 40% of Vantage Allowable. **Not included in the Out-of-Pocket Maximum.**
Leaving Against Medical Advice (AMA): Services related to Member non-compliance, including leaving against medical advice (AMA). Regardless of the mental or emotional condition present at the time of the incident.	60% Coverage of Vantage Allowable. Member pays 40% of Vantage Allowable. **Not included in the Out-of-Pocket Maximum.**
Pain Management: Medical Necessity criteria must be met.  **Requires Pre-Authorization**.	**Facility**: The lesser of: a) 60% of Vantage Allowable or b) the Vantage Allowable less the Member's applicable ASU/outpatient surgery Co-payment. Member is responsible for the greater of: a) 40% of the Vantage Allowable or b) the Member's applicable ASU/outpatient surgery Co-payment. **Not included in the Out-of-Pocket Maximum.** **Physician**: 60% Coverage of Vantage Allowable. Member pays 40% of Vantage Allowable. **Not included in the Out-of-Pocket Maximum.**
Self-inflicted Injuries: Treatment for injury or Illness suffered as a result of intentionally self-inflicted injuries. Regardless of the mental or emotional condition present at the time of the incident.	60% Coverage of Vantage Allowable. Member pays 40% of Vantage Allowable. **Not included in the Out-of-Pocket Maximum.**

Mental Health and Alcohol & Chemical Dependency Services

All Covered Services in this subsection require Pre-Authorization.

Mental Health benefits shall be payable in accordance with the provisions of Louisiana R.S. 22:1043 as concerns licensed Physicians, psychologists or licensed clinical social workers.

COVERED SERVICE	TIER I IN-NETWORK COVERAGE	OUT-OF-NETWORK* (SUBJECT TO OUT-OF-NETWORK DEDUCTIBLE)
Outpatient Mental Health Services: Includes coverage for mental illness and the following severe mental illnesses: ► Anorexia ► Bipolar disorder ► Bulimia ► Intermittent explosive disorder ► Major depressive disorder ► Obsessive-compulsive disorder ► Panic disorder ► Posttraumatic stress disorder ► Psychosis not otherwise specified when diagnosed in a Child under 17 years of age ► Rett's Disorder ► Schizophrenia or schizoaffective disorder ► Tourette's Disorder **Requires Pre-Authorization**.	**Facility:** 100% Coverage of Vantage Allowable less **$45.00** Co-payment per visit. **Not included in the Out-of-Pocket Maximum.** **Physician:** 100% Coverage of Vantage Allowable less applicable **$15.00** Primary Care Physician or **$45.00** Specialty Care Provider Co-payment per visit. **Not included in the Out-of-Pocket Maximum.**	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
Inpatient Mental Health Services: Includes coverage for mental illness and the following severe mental illnesses: ► Anorexia ► Bipolar disorder ► Bulimia ► Intermittent explosive disorder ► Major depressive disorder ► Obsessive-compulsive disorder ► Panic disorder ► Posttraumatic stress disorder ► Psychosis not otherwise specified when diagnosed in a Child under 17 years of age ► Rett's Disorder ► Schizophrenia or schizoaffective disorder ► Tourette's Disorder **Requires Pre-Authorization**.	100% Coverage of Vantage Allowable less **$150.00** inpatient Co-payment per day up to **$450.00** maximum per admission.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.

* When you seek treatment from an Out-of-Network Provider, the charges may be more than the Vantage Allowable. The Out-of-Network Provider may balance bill you for any charges over the Vantage Allowable. In-Network Providers cannot balance bill Members. All services performed by Out-of-Network Providers require Pre-Authorization.

Mental Health and Alcohol & Chemical Dependency Services (continued)

COVERED SERVICE	TIER I IN-NETWORK COVERAGE	OUT-OF-NETWORK* (SUBJECT TO OUT-OF-NETWORK DEDUCTIBLE)
Outpatient Alcohol & Chemical Dependency: **Requires Pre-Authorization**.	100% Coverage of Vantage Allowable less applicable **$15.00** Primary Care Physician or **$45.00** Specialty Care Provider Co-payment per visit. **Not included in the Out-of-Pocket Maximum.**	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.
Inpatient Alcohol & Chemical Dependency: **Requires Pre-Authorization**.	100% Coverage of Vantage Allowable less **$150.00** inpatient Co-payment per day up to **$450.00** maximum per admission.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable.

* When you seek treatment from an Out-of-Network Provider, the charges may be more than the Vantage Allowable. The Out-of-Network Provider may balance bill you for any charges over the Vantage Allowable. In-Network Providers cannot balance bill Members. All services performed by Out-of-Network Providers require Pre-Authorization.

Explanation of Approved Transplant Services
(NO OUT-OF-NETWORK COVERAGE)

All Covered Services in this subsection require Pre-Authorization.

- ► It is the Member's responsibility to ensure that all requested services are reviewed and authorized by Vantage prior to provision of those services. Failure to do so for any transplant-related service will result in non-payment of those services. In order to be approved by Vantage for payment, the transplant services must be included in Vantage coverage (see below) and performed at a designated Vantage transplant facility and deemed Medically Necessary and appropriate for the medical condition for which the transplant is proposed.
- ► Approved Transplant Services is defined to include all Medically Necessary health services and supplies rendered at a Designated Transplant Facility (defined below) during the Benefit Period which are related to transplantation, and approved in writing by Vantage prior to the delivery of any services. Such services shall include, but are not limited to, Hospital charges, Physician charges, organ procurement and tissue typing, and ancillary services rendered during the Benefit Period. Only for the purposes of this benefit, a Benefit Period is defined as the period of time from the date the Member receives prior authorization and an initial evaluation for the transplant procedure, until the earliest of: (a) one year from the date the transplant procedure was actually performed; (b) the date coverage under this Plan terminates; (c) the date of the Member's death; or (d) the date the maximum benefit for transplant Covered Services is reached.
- ► A Designated Transplant Facility is defined as a facility that has entered into an agreement with Vantage to render Approved Transplant Services. The Designated Transplant Facility will be determined by Vantage and may or may not be located within the Member's geographic area. Applications from transplant facilities shall be considered and approved by Vantage in accordance with the requirements of Louisiana R.S. 22:1231 and 22:1232.
- ► Approved Transplant Services include (a) kidney; (b) bone marrow or peripheral stem cell transplantation (except in conjunction with High Dose Chemotherapy for the treatment of solid tumors including breast cancer unless coverage is extended by the Utilization Review/Quality Management Committee); (c) liver, for biliary atresia in Children; (d) cornea; (e) heart; (f) heart-lung; (g) adult liver; (h) pancreas; (i) lung (single/double); and (j) kidney/pancreas.
- ► No benefits are payable under this Transplant Benefit for: (a) organ transplants which are not listed as Approved Transplant Services, (b) animal to human transplants; (c) artificial or mechanical devices designed to replace human organs; (d) services required to keep a donor alive for the transplant operation; (e) charges related to donor services; or (f) transplants otherwise excluded by the Plan.

Inpatient and/or ASU/outpatient surgery related to Approved Transplant Services do not apply to the Out-of-Pocket Maximum.

Transplant Services require Pre-Authorization.

There is no Tier II or Out-of-Network coverage for Approved Transplant Services.

Tier I In-Network Coverage: 100% Coverage of the Vantage Allowable less applicable Inpatient or ASU/Outpatient Surgery Co-payment.

Prescription Drug Benefits
(NO OUT-OF-NETWORK COVERAGE)

Vantage reserves the right to make changes to its Plan Drug Formulary and which tier Prescription Drugs are listed at any time during your Benefit Period. Your pharmacy plan is mandatory generic meaning if a brand name Prescription Drug is available as a Generic Drug and you receive the brand name Prescription Drug, you pay the Generic Drug Co-insurance and the difference between the cost of the brand name Prescription Drug and the cost of the Generic Drug. The difference does not apply to the Prescription Drug Out-of-Pocket Threshold.

All Prescription Drugs dispensed according to the Vantage Plan Drug Formulary and incidental to outpatient care prescribed by a Participating Physician and dispensed by a Participating pharmacy are covered at the current Vantage Participating pharmacy reimbursement rate less the applicable Member cost share not to exceed a consecutive 30-day supply of a Prescription Drug, unless limited by the manufacturer's packaging.

The Drugs included in the Plan Drug Formulary are selected by the Plan with the help of a team of doctors and pharmacists. All Prescription Drugs included in the Plan Drug Formulary are either approved by the Food and Drug Administration ("FDA") for the diagnosis or condition for which it is being prescribed or supported by the American Hospital Formulary Service Drug Information book, the DRUGDEX Information System, and the USPDI or its successor. Vantage's team of doctors and pharmacists perform a comprehensive review and update of the Plan Drug Formulary annually, but revisions are made monthly as new updates are released by the FDA.

Specialty Drugs must be provided by the Plan's contracted specialty pharmacy. When Specialty Drugs are not provided by the Plan's contracted specialty pharmacy, regardless of place of service (e.g., inpatient, outpatient, Physician's office, etc.), Pre-Authorization is required and the Plan's payment is limited to what the Plan would have paid its specialty pharmacy less the Member's Cost Share. Specialty Drugs will be subject to the Specialty Drug Co-insurance. Specialty Drugs include high cost drugs and pharmaceuticals produced through DNA technology or biological processes that target chronic or complex disease states and require unique handling, distribution, or administration as well as a customized medical management program for successful use.

Prescription Drugs associated with an approved out-of-area emergency will be covered at an amount not to exceed the current Vantage Participating pharmacy reimbursement rate less applicable cost share. The remaining amount is the Member's financial responsibility.

Vantage is responsible for the payment of applicable local sales tax on the cost of Prescription Drugs unless the cost of the Prescription Drug is less than the Member's Co-payment, in which case the Member would pay that lesser amount including any applicable sales tax.

Some Prescription Drugs require Pre-Authorization. All Specialty Drugs require Pre-Authorization.

Mail Order is not available for Specialty Drugs.

See Section VI of this Certificate for applicable pharmacy benefit exclusions and limitations.

Prescription Drug Benefits (continued)

PRESCRIPTION DRUG BENEFIT	TIER I IN-NETWORK COVERAGE
Tier I: Generic Prescription Drugs (Low-cost Generics)	**$10** Co-payment per Generic Drug prescription order or refill up to a 30-day supply.
Tier II: Preferred Prescription Drugs	**$45** Co-payment per Preferred Drug prescription order or refill up to a 30-day supply.
Tier III: Non-Preferred Prescription Drugs	**$85** Co-payment per Non-Preferred Drug prescription order or refill up to a 30-day supply.
Tier IV: Specialty Prescription Drugs	**25%** Co-insurance per Specialty Drug prescription order or refill up to a 30-day supply.
Mail Order **Tiers I, II and III:** **Tier IV:**	 30-day supply for 1 Co-payment 60-day supply for 2 Co-payments 90-day supply for 3 Co-payments Not available.

Additional Benefits Information

Telemedicine: Covered Services performed via transmitted electronic imaging or telemedicine will not be denied on the basis that such Covered Services are performed via transmitted electronic imaging or telemedicine.

Continuity Of Care: If any Health Care Provider in the Vantage network is in the process of being contractually terminated or has been terminated and that Health Care Provider is rendering services to a Member that has been diagnosed as having a high-risk pregnancy or is past the 24th week of pregnancy or has been diagnosed with a Life-Threatening Illness or acute condition, the Member may continue to receive Covered Services from the Health Care Provider until the delivery and discharge of the child from the Hospital or until the course of treatment is completed, not to exceed six months from the effective date of contract termination, whichever situation is applicable. However, in the event that the termination or proposed termination of the Health Care Provider's contract is the result of suspension or revocation by the State of Louisiana of the Health Care Provider's license to practice in Louisiana, then this Continuity of Care provision shall not apply.

Travel Benefit: Limited travel arrangements may be covered **ONLY** if we require you to travel outside the Vantage Service Area to obtain treatment that could be provided locally, but only by Out-of-Network Providers. Call the Vantage Medical Management department at (318) 361-0900 for details.

Federal Disclosure Concerning Hospital Length Of Stay In Connection With Childbirth: Vantage will not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or Newborn to less than 48 hours following a vaginal delivery, or less than 96 hours following a Caesarean section. However, Federal law generally does not prohibit the mother's or Newborn's attending provider, after consulting with the mother, from discharging the mother or her Newborn earlier than 48 hours (or 96 hours as applicable). Vantage shall not require that a provider obtain authorization to prescribe a length of stay less than 48 hours following delivery (or 96 hours as applicable). With the exception of emergency services or emergency admission to a Hospital related to childbirth, Vantage still requires Pre-Authorization prior to being admitted to a Hospital for delivery.

Wellness or Health Improvement Programs:
Vantage may offer a voluntary wellness or health improvement program that allows incentives to encourage participation in the program.

Clinical Cancer Trials

Vantage shall provide coverage for the cost of healthcare services, treatments or testing, that are incurred as part of the protocol treatment being provided to the Member for purposes of a clinical trial. Costs for investigational treatments and protocol related patient care shall be covered if all of the following criteria are met:

- ► The treatment is being provided with a therapeutic or palliative intent for patients with cancer, or for the prevention or early detection of cancer, and
- ► The treatment is being provided or the studies are being conducted in a Phase II, Phase III, or Phase IV clinical trial for cancer, and
- ► The treatment is being provided in accordance with a clinical trial approved by one of the following entities:
  - The United States National Institutes of Health (NIH)
  - A cooperative group funded by the NIH
  - The Federal Food and Drug Administration in the form of an investigational New Drug Application
  - The United States Department of Veteran Affairs
  - The United States Department of Defense
  - A federally funded general clinical research center
  - The Coalition of National Cancer Cooperative Groups; and
- ► The proposed protocol has been reviewed and approved by a qualified institutional review board which operates in this state and which has a multiple project assurance contract approved by the office of protection from research risks, and
- ► The facility and personnel providing the protocol provided the treatment within their scope of practice, experience, and training and are capable of doing so by virtue of their experience, and
- ► There is no clearly superior, non-investigational approach; and
- ► The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as efficacious as the non-investigational alternative; and
- ► The Member has signed an institutional review board approved consent form.

SECTION V: BENEFIT MAXIMUMS

The maximum liability under this Plan for Covered Services paid for each Member shall be limited to the following:

- **AMBULANCE SERVICES**
  The maximum benefit for ground ambulance services is $350 per day and is included in the Maximum Annual Benefit Limit below. The maximum benefit air ambulance services $1,500 per day and is included in the Maximum Annual Benefit Limit below.

- **DURABLE MEDICAL EQUIPMENT**
  The maximum benefit for Durable Medical Equipment Covered Services, excluding Prosthetic Devices and Prostheses, for each Member shall be $50,000 during the lifetime of the Member and is included in the Maximum Annual Benefit Limit below. The maximum benefit for Prosthetic Devices and Prostheses Covered Services for each Member shall be $50,000 per limb per Benefit Period and is included in the Maximum Annual Benefit Limit below.

- **HEARING AID FOR MINOR MEMBER**
  A maximum benefit limit of $1,400 shall apply per hearing aid for each impaired ear not to exceed one per impaired ear every thirty-six (36) months and is included in the Maximum Annual Benefit Limit below.

- **AUTISM SPECTRUM DISORDERS**
  The maximum benefit for all Autism Spectrum Disorder Covered Services for each Member shall be $36,000 per Benefit Period and is included in the Maximum Annual Benefit Limit below.

- **DIABETES MANAGEMENT**
  The maximum benefit for all Diabetes Management Covered Services shall be $500 per Benefit Period and is included in the Maximum Annual Benefit Limit below.

- **LOW PROTEIN FOODS FOR TREATMENT OF INHERITED METABOLIC DISEASES**
  The maximum benefit limit for low protein foods intended to be used for the Medically Necessary dietary treatment of certain inherited metabolic diseases shall be $200 per month and is included in the Maximum Annual Benefit Limit below.

- **APPROVED TRANSPLANT SERVICES MAXIMUM**
  The maximum annual benefit for all Approved Transplant Services for each Member shall be $500,000 and is included in the Maximum Annual Benefit Limit below.

- **MAXIMUM ANNUAL BENEFIT LIMIT**
  The maximum annual benefit limit for Eligible Charges and Prescription Drug payments made by Vantage for each Member shall be $2,000,000 during the Benefit Period, which includes the following:
  1. $350 daily maximum benefit for ground ambulance services and $1,500 daily maximum benefit for air ambulance services;
  2. $50,00 lifetime maximum benefit for Durable Medical Equipment, excluding Prosthetic Devices and Prostheses;
  3. $50,000 annual maximum benefit per limb for Prosthetic Devices and Prostheses;
  4. $1,400 maximum benefit per impaired ear for hearing aids for minor Members;
  5. $36,000 annual maximum benefit for Autism Spectrum Disorders;
  6. $500 maximum benefit for Diabetes Management;
  7. $200 monthly maximum benefit for low protein foods for treatment of inherited metabolic diseases; and
  8. $500,000 maximum annual benefit for all Approved Transplant Services.

SECTION VI: EXCLUSIONS & LIMITATIONS

Coverage shall not be provided and no payment shall be made under this Plan for services or expenses incurred in connection with:

1. Accidental Bodily Injury or sickness arising out of, or in the course of, employment entitling the Member to benefits under Workers' Compensation, Occupational Disease or any similar Federal or State law.

2. Any incidental procedure, unbundled procedure, or mutually exclusive procedure.

3. Losses, injuries, or contracted diseases which are due to insurrection, war, or any act of war, whether declared or undeclared.

4. Losses or injuries suffered as a result of participating in a riot, civil disturbance or while committing or attempting to commit a crime or treatment of any Member confined in a prison, jail, or other penal institution.

5. Treatment or care for which there is no legal obligation of Vantage or the Plan to pay. The existence of this Plan will not create an obligation to pay.

6. Services or supplies, which are not Medically Necessary for the treatment of Illness, injury, or symptomatic complaint. The fact that a Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make it Medically Necessary to make the charge a Covered Service, even though the service or supply is not specifically listed as an exclusion. The final approval and discretion for determining whether services or supplies or days of care are Medically Necessary lies solely with Vantage.

7. Any treatment or services rendered for orthodontic, periodontic, orthognathic, including temporomandibular joint (TMJ), or dental implants.

8. Services, surgery, supplies, treatment, or expenses received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group.

9. Eyeglasses, contact lenses, corneal surgery (except corneal transplants as specified), and hearing aids (including testing and follow-up). NOTE: See *Section IV: Schedule of Covered Services and Benefits* for minor Members under the age of 18 eligible for hearing aids.

10. Services, surgery, supplies, treatment, or expenses in connection with or related to:
    a. Eye exercises, visual training, or orthoptics;
    b. The correction of refractive errors of the eye, including, but not limited to, radial keratotomy and laser surgery; or
    c. Visual therapy.

11. Services or supplies for purely Cosmetic Purposes (including cosmetic surgery) or for complications resulting from treatment/procedures for Cosmetic Purposes (including Reconstructive Services secondary to a cosmetic procedure):
    a. To change the texture or appearance of the skin (including, but not limited to, the treatment of acne); or
    b. To change the relative size or position of any part of the body (such as enlargement, reduction, or implantation) when such surgery is performed primarily to improve an

individual's physical appearance and does not improve the function or usefulness of the body; or

c. To eliminate psychological stress or impairment; or
d. Treatment the sole purpose of which is to promote or stimulate hair growth; or
e. Hair pieces, wigs, or hair implants.

NOTE: Reconstructive services and supplies will be covered if Medically Necessary and due to Accidental Bodily Injury or organic Illness suffered, including reconstruction to produce a symmetrical appearance of the breasts following a mastectomy, provided the mastectomy was performed under this Plan.

12. Services, surgery, supplies, treatment, or expenses in connection with or related to, or complications from the following regardless of claim of Medical Necessity:
    a. rhinoplasty;
    b. blepharoplasty services identified by CPT codes 15820, 15821, 15822, 15823; brow ptosis identified by CPT code 67900; or any revised or equivalent codes;
    c. gynecomastia;
    d. breast enlargement or reduction, except for breast Reconstructive Services as specifically provided in this Certificate of Coverage;
    e. implantation, removal and/or re-implantation of breast implants and services, Illnesses, conditions, complications and/or treatment in relation to or as a result of breast implants;
    f. implantation, removal and/or re-implantation of penile prosthesis and services, Illnesses, conditions, complications and/or treatment in relation to or as a result of penile prosthesis;
    g. diastasis recti; or
    h. idiopathic short stature.

13. Surgical and medical treatment for snoring in the absence of obstructive sleep apnea, including laser-assisted uvulopalatoplasty (LAUP).

14. Penile implant devices and related supplies.

15. Pregnancy, childbirth, or related medical conditions, excluding wellness and preventive care Covered Services, for Members other than the Employee or covered spouse.

16. Paternity tests and tests performed for legal purposes.

17. Genetic Testing, unless the results are specifically required for a medical treatment decision on the Member, or required by law.

18. Treatment of and services related to infertility, including surgical procedures to reverse voluntarily induced sterilization, in vitro fertilization and artificial insemination, and treatment and services related to surrogate pregnancies, and Drugs related to treatment of infertility.

19. Personal comfort and convenience items.

20. Any procedures, services, Drugs or supplies, or benefits which are experimental or investigational in nature and certain newly introduced technologies, Drugs or other treatment. The fact that a Physician may prescribe, order, recommend or approve a procedure, service, Drug or supply does not mean that such service or supply is not experimental or investigational. The final determination as to whether any given service or supply is excluded under this section lies within the sole discretion of Vantage. For purposes of this section, "experimental or investigational" shall include and be defined as any treatment, service or supply for which:

a. there is no consensus in the medical community as to safety or effectiveness of the technology as applied to the particular circumstances of the Member or for treatment of the patient's particular medical problem
b. there is insufficient evidence to determine its appropriateness in a given situation;
c. the technology warrants further study or is in the process of undergoing clinical trials, particularly if undergoing Phase I, II or III clinical trials;
d. use of the technology for the given indication in the specified patient population is confined largely to research protocols; or
e. the Physician or facility rendering the treatment classifies the treatment as experimental or investigational for purposes of obtaining an informed consent.

21. Drugs and surgical procedures related to weight loss. Treatment of complications secondary to surgery for weight loss (*e.g., gastric bypass and lap band procedures*), including, but not limited to, nutritional deficits, bowel obstructions, and abdominal pain.

22. Any services or supplies related to:
    a. organ transplants which are not listed as Approved Transplant Services;
    b. animal to human transplants;
    c. artificial or mechanical devices designed to replace human organs;
    d. services to keep a donor alive for the transplant operation;
    e. charges related to donor services; or
    f. transplants otherwise excluded by this Plan.

23. Hospitalization primarily for Physical Therapy or hydrotherapy.

24. Services or supplies for physical examination for employment, licensing, travel, school, insurance, adoption, participation in athletics, or examination or treatment ordered by a court.

25. Services or supplies, which were provided prior to Member's effective date with Vantage or after Member's cancellation date for coverage with Vantage, except as otherwise provided herein.

26. Services, surgery, supplies, treatment, or expenses rendered by a provider who is the Member's spouse, child, stepchild, parent, stepparent or grandparent.

27. Whole blood and blood products that are covered under a Member's blood bank program (autologous blood bank services).

28. Services or supplies for the prophylactic storage of cord blood.

29. Megavitamin therapy, biofeedback, psychosurgery and nutrition-based therapy for alcoholism or substance abuse and mental health disorders.

30. Salabrasion, chemosurgery or other such skin abrasion procedures associated with removal of scars, tattoos, and/or which are performed as a treatment of acne scarring.

31. Services related to sex transformation.

32. Services or supplies in connection with charges for failure to keep a scheduled visit; charges for completion of a claim form, telephone charges or charges to obtain medical records.

33. Services, supplies or treatment not specifically listed as a Covered Service. This includes, but is not limited to, the following:
    a. travel or transportation, whether recommended by a Physician or not;
    b. self-help training and other forms of non-medical care;
    c. acupuncture;

d. hypnosis;
e. charges for anesthesia for non-Covered Services;
f. support hose, ace or elastic bandages, and pressure garments;
g. corrective footwear or orthotics;
h. wigs or hairpieces;
i. prosthetic garments or apparel;
j. wet nurse or milk bank services;
k. holistic medical services;
l. unproven methods of allergy testing (i.e., cytotoxic allergy testing);
m. disposable supplies; or
n. marriage/family counseling.

34. Treadmill, swimming pool, or special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program.

35. Contraceptive devices not approved by the Food and Drug Administration whether prescribed by a Physician or not, including Norplant.

36. Elective abortions except when provided to save the life of the mother.

37. Services or supplies for treatment related to and/or complications resulting from a non-Covered Service.

38. Charges in excess of the Vantage Allowable.

39. Emergency department visits for injections, Drugs, removal of sutures, or any other non-emergency service.

40. Admission to a Hospital primarily for diagnostic services which could have been provided safely and adequately in some other setting, e.g., outpatient department of a Hospital or Physician's office.

41. Services and supplies for the treatment of substance abuse in the event the patient fails to complete or comply with the phase of treatment (e.g., detoxification, rehabilitation, or outpatient care) for which the services and supplies were rendered or a claim was submitted.

42. Counseling services such as career counseling, marriage counseling, divorce counseling, parental counseling and job counseling.

43. Diagnosis or care and treatment of:
    a. weak, strained, unstable or flat feet;
    b. toenails (except for the diabetic patient or treatment of ingrown toenails);
    c. cutting or removal of superficial lesions of the feet such as corns, calluses or hyperkeratosis (except as warranted for the diabetic patient);
    d. tarsalgia, metatarsalgia or bunions, except surgery which involves exposure of bones, tendons, or ligaments; or
    e. other services performed in the absence of localized Illness or injury.

44. Body piercing or complications due to body piercing. Injuries related to objects being inserted or removed from a pierced body part whether accidental or purposeful. Reconstructive Services or surgery to repair damage due to body piercing whether directly or indirectly. Tattoos and the treatment of complications from tattoos including, but not limited to, infections and Hepatitis.

45. Magnet therapy, external bone growth stimulators, spinal cord stimulators, artificial spinal disc, electro-muscular stimulators and implanted devices for pain control.

46. Physical Therapy for Chronic or Recurrent conditions, including fibromyalgia and muscle tension headaches. Physical Therapy is not covered when maintenance level of therapy is attained as determined by your Physician and/or a Vantage Medical Director.

47. Occupational Therapy is not covered when maintenance level of therapy is attained as determined by your Physician and/or a Vantage Medical Director.

48. Professional charges for clinical lab.

49. Anodyne (infrared) treatments.

50. Treatment for varicose veins and telangiectasia by any method including, but not limited to, endovenous laser treatments, sclerosis or surgical stripping.

51. Pulmonary rehabilitation.

52. The cost of health care services, treatment or testing for clinical cancer trials except as provided for in the Schedule of Covered Services and Benefits section of this Certificate.

53. Botox used for the treatment of hyperhydrosis, migraine headaches, musculoskeletal pain, fibromyalgia or other conditions not specifically listed as covered.

54. Separate anesthesia charges for endoscopies.

55. Custodial Care.

56. Out-patient private-duty nursing.

57. Durable and non-durable medical supplies (except as specified by Vantage).

58. Psychological or educational testing services for any reason including, but not limited to, testing services related to the diagnosis or treatment of Developmental Disorder or delay, learning disorders or disability, attention deficit disorders or hyperactivity.

59. Listening therapy or auditory therapy.

60. Anti-aging treatment, including but not limited to office visits, laboratory tests, hormone treatments, and other services associated with anti-aging treatment.

61. Items or services provided by Medicare Opt-Out Physicians.

62. Services and treatments related to Mental Health and/or Chemical and Alcohol Dependency provided in residential treatment centers.

63. Drug screenings performed solely to ensure compliance with medical treatments.

64. Member reimbursements other than those submitted with itemized procedures and diagnoses documented by a Provider.

65. Extraction of wisdom teeth.

66. Pharmacy benefit exclusions and limitations:
    a. Nicorette and other Drugs to assist in smoking cessation, except as specified by Vantage;
    b. Retin-A (except for acne) or other like products for Cosmetic Purposes;

c. Minoxidil and Rogaine or other like products for hair loss;
d. Appetite suppressants;
e. Drugs received at Out-of-Network pharmacies;
f. Drugs related to treatment of infertility;
g. Drugs for the treatment of an Illness for which there is no FDA approval for such use except when medically appropriate and an accepted standard of practice;
h. Drugs used for experimental indications and/or dosage regimens determined by Vantage to be experimental;
i. Non-prescription drugs, including over-the-counter (OTC) medicine and supplement products, except as specified by Vantage;
j. Any Prescription Drug that is equivalent to an OTC medicine or OTC supplement product, except as specified by Vantage;
k. Replacement Drugs resulting from loss or theft;
l. The *additional* cost for multi-source Prescriptions Drugs which are not dispensed in accordance with the Plan Drug Formulary, whether the request for the Prescription Drug originates with the Member or a Participating Physician;
m. Any Drug which is listed as not covered;
n. Prescription Drugs written for quantities in excess of the covered benefit;
o. Implantable Drugs for hormone replacement therapy, pain control or any other reason;
p. Compounded Drugs;
q. Pharmacy benefits when Vantage is not the primary insurer;
r. Drugs for the treatment of obesity and weight loss;
s. Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations;
t. Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra and Caverject;
u. Growth hormone therapy unless an endocrinologist confirms growth hormone deficiency with an abnormal provocative stimulation test;
v. Prescription Drugs for and/or treatment of idiopathic short stature; or
w. Abortifacient drugs.

SECTION VII: ELIGIBILITY FOR COVERAGE

I. PERSONS TO BE COVERED

Eligibility requirements apply to all Participants in the Program.

A. Employee Coverage

1. Employee

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

2. Husband and Wife, Both Employees

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

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

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

   a) If employment begins on the first day of the month, coverage is effective on the first day of the following month (For example, if hired on July 1, coverage will begin on August 1);

   b) If employment begins on or after the second day of the month, coverage is effective on the first day of the second month following employment (For example, if hired on July 15, coverage will begin on September 1);

   c) Employee coverage will not become effective unless the Employee completes an Enrollment Form within 30 days following the date of employment. If completed after 30 days following the date of employment, the Employee will be considered an overdue applicant.

   d) An Employee who transfers employment to another Participating Employer must complete a Transfer Form within 30 days following the date of transfer to maintain coverage without interruption. If completed after 30 days following the date of transfer, the Employee will be considered an overdue applicant.

4. Re-Enrollment and Previous Employment for Health Benefits

   a) An Employee, whose employment terminated while covered and is re-employed within 12 months of the termination date, will be considered a Re-Enrollment Previous Employment applicant. A Re-Enrollment Previous Employment applicant will only be eligible for the classification of coverage (Employee, Employee and Child(ren), Employee and Spouse, Family) in force on the effective termination date.

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

5. Members of Boards and Commissions

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

6. Legislative Assistants

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

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

   a) The terms of the following paragraphs apply to all eligible Employees and their Dependents whose employment with a Participating Employer begins on or after July 1, 2001.

   b) The Program may require that such applicants complete a "Statement of Physical Condition" form and an "Acknowledgment of Pre-existing Condition" form.

   c) Medical expenses incurred during the first 12 months following enrollment of the Employee and/or Dependent will not be considered as covered medical expenses if they are in connection with a disease, Illness, Accident, or injury for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately prior to the Enrollment Date. The provisions of this section do not apply to pregnancy.

   d) If the Covered Person was previously covered under a Group Health Plan, Medicare, Medicaid, or other Creditable Coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), credit will be given for previous coverage that occurred without a break for 63 days or more for the duration of prior coverage against the initial 12-month period. Any coverage occurring prior to a break in coverage 63 days or more will not be credited against a pre-existing condition exclusion period.

   e) The foregoing notwithstanding, Vantage does not exclude coverage based upon pre-existing condition limitations for Members enrolling in the Regional HMO Plan. However, if a Member chooses to disenroll from the Regional HMO Plan and transfer to a standard OGB plan (PPO, HMO or CD-HSA) during annual enrollment, and the transfer of coverage is effective before the 12-month exclusionary period has lapsed, the pre-existing condition limitation will apply under the new plan. Under the new plan, the pre-existing condition limitations do not apply to new Employees and/or their Dependents over the age of nineteen (19).

B. Retiree Coverage

1. Eligibility

   a) Retirees of Participant Employers are eligible for Retiree coverage under this Plan.

   b) An Employee retired from a Participant Employer may not be covered as an Employee.

   c) **RETIREES ARE NOT ELIGIBLE FOR COVERAGE AS LATE ENROLLEES**.

2. Effective Date of Coverage

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

C. Dependent Coverage

1. Eligibility

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

   a) The date the Employee becomes eligible;

   b) The date the Retiree becomes eligible;

   c) The date the covered Employee or covered Retiree acquires a Dependent.

2. Effective Dates of Coverage

   a) Dependents of Employees

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

   b) Dependents of Retirees

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

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

1. The terms of the following paragraphs apply to all eligible Employees who apply for coverage after 30 days from the date the Employee became eligible for coverage and to all eligible Dependents of Employees and Retirees for whom the application for coverage was not completed within 30 days from the Date Acquired for Members enrolling in the standard plans (PPO, HMO or CD-HSA).

   The effective date of coverage will be:

   a) The first day of the month following the date the Program receives all required forms prior to the 15th of the month;

   b) The first day of the second month following the date the Program receives all required forms on or after the 15th of the month.

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

3. Medical expenses incurred during the first 12 months following enrollment of the Employee and/or Dependent will not be considered as covered medical expenses if they are in connection with a disease, Illness, Accident, or injury for which medical advice, diagnosis, care, or treatment was recommended or received during the six-month period immediately prior to the Enrollment Date. The provisions of this section do not apply to pregnancy.

4. If the Covered Person was previously covered under a Group Health Plan, Medicare, Medicaid or other Creditable Coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), credit will be given for previous coverage that occurred continuously for 63 days or more for the duration of prior coverage against the initial 12-month period. Any coverage occurring prior to a break in coverage 63 days or more will not be credited against a pre-existing condition exclusion period.

5. The foregoing notwithstanding, Vantage does not exclude coverage based upon pre-existing condition limitations for Members enrolling in the Regional HMO Plan. However, if a Member chooses to disenroll from the Regional HMO Plan and transfer to a standard OGB plan (PPO, HMO or CD-HSA) during annual enrollment, and the transfer of coverage is effective before the 12-month exclusionary period has lapsed, the pre-existing condition limitation will apply under the new plan.

E. Special Enrollments – HIPAA

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

1. Loss of Other Coverage

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

   a) Loss of eligibility through separation, divorce, termination of employment, reduction in hours, or death of the Plan Participant; or

   b) Cessation of Participant Employer contributions for the other coverage, unless the Participant Employer's contributions were ceased for cause or for failure of the individual Participant to make contributions; or

   c) The Employee or Dependent having had COBRA continuation coverage under a Group Health Plan and the COBRA continuation coverage has been exhausted, as provided in HIPAA.

2. After Acquired Dependents

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

   a) A special enrollment application must be made within 30 days of either the termination date of the prior coverage or the date the new Dependent is acquired. If it is made more than 30 days after eligibility, they will be considered overdue applicants subject to a pre-existing condition limitation.

   b) The effective date of coverage shall be:

      i. For loss of other coverage or marriage, the first day of the month following the date the Program receives all required forms for enrollment;
      ii. For birth of a Dependent, the date of birth;
      iii. For adoption, the date of adoption or Placement for Adoption.

   c) Special enrollment applicants must complete the "Acknowledgment of Pre-existing Condition" form and "Statement of Physical Condition" form. Vantage does not exclude coverage based upon pre-existing condition limitations for Members enrolling in the Regional HMO Plan. However, if a Member chooses to disenroll from the Regional HMO Plan and transfer to a standard OGB plan (PPO, HMO or CD-HSA) during annual enrollment, and the transfer of coverage is effective before the 12-month exclusionary period has lapsed, the pre-existing condition limitation will apply under the new plan.

   d) Medical expenses incurred during the first 12 months that coverage for the special enrollee is in force under this Plan will not be considered as covered medical expenses if they are in connection with a disease, Illness, Accident, or injury for which medical advice, diagnosis, care, or treatment was recommended or received during the six-month period immediately prior to the Enrollment Date. The provisions of this section do not apply to pregnancy.

   e) If the special enrollee was previously covered under a Group Health Plan, Medicare, Medicaid or other Creditable Coverage as defined in HIPAA, the duration of the prior coverage will be credited against the initial 12-month period used by the Program to exclude benefits for a pre-existing condition if the termination under the prior coverage occurred within 63 days of the date of coverage under the Plan.

F. Retirees Special Enrollment

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

1. Retirement began on or after July 1, 1997;

2. The Retiree has exhausted all COBRA and/or other continuation rights and has made a formal request to enroll within 30 days of the loss of other coverage; and
3. The Retiree has lost eligibility to maintain other coverage through no fault of his/her own.

G. Regional Health Maintenance Organization (HMO) Plan Option

1. In lieu of participating in the standard plans (PPO, HMO or CD-HSA), Employees and Retirees may elect coverage under an approved Regional HMO Plan.
2. New Employees may elect to participate in the Regional HMO Plan during their initial period of eligibility. Each Regional HMO Plan will hold an annual enrollment period. Transfer of coverage from the standard plans (PPO, HMO or CD-HSA) to the Regional HMO Plan or vice-versa will only be allowed during the annual enrollment period.

   Transfer of coverage will be allowed as a result of the Employee being transferred into or out of the Regional HMO Plan geographic service area, with an effective date of the first day of the month following transfer.
3. If a Covered Person has elected to transfer coverage but is hospitalized on the effective date of coverage under a different plan, the plan providing coverage prior to the effective date of coverage, will continue to provide coverage up to the date of discharge from the Hospital.

H. TRICARE for Life Option for Military Retirees

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

II. CONTINUED COVERAGE

A. Leave of Absence

1. Leave of Absence without Pay, Employer Contributions to Premiums
   a) A participating Employee who is granted leave of absence without pay due to a service related injury may continue coverage and the Participating Employer shall continue to pay its portion of health plan premiums for up to 12 months.

   b) A participating Employee who suffers a service related injury that meets the definition of a total and permanent disability under the worker's compensation laws of Louisiana may continue coverage and the Participating Employer shall continue to pay its portion of the premium until the Employee becomes gainfully employed or is placed on state disability retirement.

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

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

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

B. Disability

1. Employees who have been granted a waiver of premium for Basic or Supplemental Life Insurance prior to July 1, 1984 may continue health coverage for the duration of the waiver if

the Employee pays the total contribution to the Participant Employer. Disability waivers were discontinued effective July 1, 1984.

2. If a Participant Employer withdraws from the Plan, health and life coverage for all Covered Persons will terminate on the effective date of withdrawal.

C. Surviving Dependents/Spouse

1. Benefits under the Plan for covered Dependents of a deceased covered Employee or Retiree will terminate on the last day of the month in which the Employee's or Retiree's death occurred unless the surviving covered Dependents elect to continue coverage.

   a) The surviving legal Spouse of an Employee or Retiree may continue coverage unless or until the surviving Spouse is or becomes eligible for coverage in a Group Health Plan other than Medicare;

   b) The surviving, never married Dependent Child of an Employee or Retiree may continue coverage unless or until such Dependent Child is or becomes eligible for coverage under a Group Health Plan other than Medicare or until attainment of the termination age for Children, whichever occurs first;

   c) Surviving Dependents will be entitled to receive the same Participant Employer premium contributions as Employees and Retirees, subject to the provisions of Louisiana Revised Statutes, Title 42, Section 851 and rules promulgated pursuant thereto by the Office of Group Benefits;

   d) Coverage provided by the Civilian Health and Medical Program for the Uniform Services (CHAMPUS/TRICARE) or successor program will not be sufficient to terminate the coverage of an otherwise eligible surviving legal Spouse or a Dependent Child.

2. A surviving Spouse or Dependent cannot add new Dependents to continued coverage other than a Child of the deceased Employee born after the Employee's death.

3. Participant Employer/Dependent Responsibilities

   a) It is the responsibility of the Participant Employer and surviving covered Dependent to notify the Program within 60 days of the death of the Employee or Retiree;

   b) The Program will notify the surviving Dependents of their right to continue coverage;

   c) Application for continued coverage must be made in writing to the Program within 60 days of receipt of notification, and premium payment must be made within 45 days of the date continued coverage is elected for coverage retroactive to the date coverage would have otherwise terminated;

   d) Coverage for the surviving Spouse under this section will continue until the earliest of the following :

      i. Failure to pay the applicable premium timely;
      ii. Eligibility of the surviving Dependent Child under a Group Health Plan other than Medicare.

   e) Coverage for a surviving Dependent Child under this section will continue until the earliest of the following events:

      i. Failure to pay the applicable premium timely;
      ii. Eligibility of the surviving Dependent Child for coverage under any Group Health Plan other than Medicare; or
      iii. The attainment of the termination age for Children.

4. The provisions of paragraphs 1 through 3 this subsection are applicable to surviving Dependents who, on or after July 1, 1999, elect to continue coverage following the death of an Employee or Retiree. Continued coverage for surviving Dependents who made such election before July 1, 1999, shall be governed by the rules in effect at the time.

D. Over-Age Dependents

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

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

E. Military Leave

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

1. Health Plan Participation

When called to active military duty, participating Employees and covered Dependents may:

a) Continue participation in the OGB health plan during the period of active military service, in which case the Participating Employer may continue to pay its portion of premiums; or

b) Cancel participation in the OGB health plan during the period of active military service, in which case such Plan Participants may apply for reinstatement of OGB coverage within 30 days of:

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

III. COBRA

A. Employees

1. Coverage under this Plan for a covered Employee will terminate on the last day of the calendar month during which employment is terminated (voluntarily or involuntarily) or significantly reduced, the Employee no longer meets the definition of an Employee, or coverage under a Leave of Absence expires unless the covered Employee elects to continue coverage at the Employee's own expense. Employees terminated for gross misconduct are not eligible for COBRA coverage.
2. It is the responsibility of the Participant Employer to notify the Program within 30 days of the date coverage would have terminated because of any of the foregoing events and the Program will notify the Employee within 14 days of his or her right to continue coverage.
3. Application for continued coverage must be made in writing to the Program within 60 days of the date of the election notification, and premium payment must be made within 45 days of the date the Employee elects continued coverage, for coverage retroactive to the date it would have otherwise terminated.

4. Coverage under this section will continue until the earliest of the following:
    a) Failure to pay the applicable premium timely:
    b) 18 months from the date coverage would have otherwise terminated;
    c) entitlement to Medicare;
    d) Coverage under a Group Health Plan, but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the Covered Person have been exhausted or satisfied; or
    e) The Employer ceases to provide any Group Health Plan for its Employees.
5. If employment for a covered Employee is terminated (voluntarily or involuntarily) or significantly reduced, the Employee no longer meets the definition of an Employee, or Leave of Absence has expired, and the Employee has not elected to continue coverage, the covered spouse and/or Dependent Children may elect to continue coverage at his/her/their own expense. The elected coverage will be subject to the above stated notification and termination provisions.

B. Surviving Dependents

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

C. Divorced Spouse

1. Coverage under this Plan for an Employee's spouse will terminate on the last day of the month during which dissolution of the marriage occurs by virtue of a legal decree of divorce from the Employee or Retiree, unless the covered divorced Spouse elects to continue coverage at his or her own expense.
2. It is the responsibility of the divorced Spouse to notify the Program within 60 days from the date of divorce, and the Program will notify the divorced Spouse within 14 days of his or her right to continue coverage. Application for continued coverage must be made in writing to the Program within 60 days of the election notification.

3. Premium payment must be made within 45 days of the date continued coverage is elected, for coverage retroactive to the date coverage would have otherwise terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.
4. Coverage for the divorced Spouse under this section will continue until the earliest of the following:
    a) Failure to pay the applicable premium timely;
    b) 36 months beyond the date coverage would have otherwise terminated;
    c) Entitlement to Medicare;
    d) Coverage under a Group Health Plan, but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the Covered Person have been exhausted or satisfied; or
    e) The Employer ceases to provide any Group Health Plan for its Employees.

D. Dependent Children

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

E. Dependents of COBRA Participants

1. If a covered terminated Employee has elected to continue coverage and if during the period of continued coverage the covered spouse or a Dependent Child becomes ineligible for coverage due to:
    a) Death of the Employee;
    b) Divorce from the Employee; or
    c) A Dependent Child no longer meets the definition of an eligible covered Dependent;

    Then, the spouse and/or Dependent Child may elect to continue COBRA coverage at his or her own expense. Coverage will not be continued beyond 36 months from the date coverage would have otherwise terminated.

2. It is the responsibility of the spouse and/or the Dependent Child to notify the Program within 60 days of the date COBRA coverage would have terminated.
3. Monthly payments for each month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.
4. Coverage for the Children under this section will continue until the earliest of the following:
    a) Failure to pay the applicable premium timely;
    b) 36 months beyond the date coverage would have otherwise terminated;
    c) Entitlement to Medicare;
    d) Coverage under a Group Health Plan, but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the Covered Person have been exhausted or satisfied; or
    e) The Employer ceases to provide any Group Health Plan for its Employees.

F. Disability COBRA

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

a) Failure to pay the applicable premium timely;

b) 29 months from the date coverage would have otherwise terminated;

c) Entitlement to Medicare;

d) Coverage under a Group Health Plan, but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the Covered Person have been exhausted or satisfied;

e) The Employer ceases to provide any Group Health Plan for its Employees; or

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

G. Medicare COBRA

1. If an Employee becomes entitled to Medicare less than 18 months before the date the Employee's eligibility for benefits under this Plan terminates, the period of continued coverage available for the Employee's covered Dependents will continue until the earliest of the following:

   a) Failure to pay the applicable premium timely;

   b) 36 months from the date of the Employee's Medicare entitlement;

   c) Entitlement to Medicare;

   d) Coverage under a Group Health Plan, but only after any pre-existing conditions exclusions of that other plan for a pre-existing condition of the Covered Person have been exhausted or satisfied; or

   e) The Employer ceases to provide any Group Health Plan for its Employees.

2. Monthly payments for each month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.

H. Miscellaneous Provisions

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

IV. CHANGE OF CLASSIFICATION

A. Adding or Deleting Dependents

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

B. Change in Coverage

1. When there is a change in family status (e.g., marriage, birth of Child) that affects the class of coverage, the change in classification will be effective on the date of the event. Application for the change must be made within 30 days of the date of the event.

2. When the addition of a Dependent changes the class of coverage, the additional premium will be charged for the entire month if the date of change occurs before the 15th day of the month. If the date of change occurs on or after the 15th day of the month, an additional premium will not be charged until the first day of the following month.

C. Notification of Change

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

V. CONTRIBUTIONS

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

SECTION VIII: TERMINATION OF COVERAGE

A. **Plan Premiums**

This Plan has a thirty (30) day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the following grace period. During the grace period, this Plan will stay in force, except that for groups where premiums have not been received when due, claims for Members covered by this Plan may, at the option of Vantage, be held and suspended from processing until the premiums have been paid by OGB. This Plan will be considered cancelled unless the premiums past due and current are fully paid by the end of the grace period. This Certificate constitutes notice of the cancellation and necessary action for reinstatement.

B. **Active Employee and Retired Employee Coverage**

Subject to continuation of coverage and COBRA rules, an Employee's coverage will terminate on the first to occur of the following:

1. The last day of the month during which the Employee no longer meets eligibility requirements under this Plan or for any specific benefit, the date the benefit terminates or the date an Employee's eligibility status changes so that Employee is no longer eligible for that benefit; or
2. the last day of the month OGB, the Participant Employer or the Employee ceases to make premium payments within the specified grace period, unless otherwise specified by OGB and approved by Vantage; or
3. the date the Program terminates or the date the Participant Employer employing the Employee terminates or withdraws from the Program; or
4. the date Vantage determines the Employee is ineligible due to material misrepresentation and/or noncompliance with Vantage procedures or breaches any provision of this Plan; or
5. the date the Employee reaches his/her Lifetime Maximum Benefit Amount; or
6. the last day of the month of the Employee's death.

The Employee will be notified by Vantage of coverage termination at his/her last known address. The Employee is responsible for the cost of all benefits which are provided after the date of termination of coverage.

C. **Dependent Coverage**

Subject to continuation of coverage and COBRA rules, Dependent coverage will terminate on the first to occur of the following:

1. The last day of the month during which the Dependent ceases to be covered, no longer meets eligibility requirements under this Plan, or for any specific benefit, the date the benefit terminates or the date a Dependent's eligibility status changes so that Dependent is no longer eligible for that benefit; or
2. the last day of the month OGB, the Participant Employer or the Employee ceases to make premium payments within the specified grace period, unless otherwise specified by the OGB and approved by Vantage; or
3. the date the Program terminates or the date the Participant Employer employing the Employee terminates or withdraws from the Program; or

4. the date Vantage determines the Dependent is ineligible due to material misrepresentation and/or noncompliance with Vantage procedures or breaches any provision of this Plan; or
5. the date the Dependent reaches his/her Lifetime Maximum Benefit Amount; or
6. the last day of the month of the Dependent's death; or
7. for grandchildren for whom the Employee does not have legal custody or has not adopted, the date the Child's parent ceases to be a covered Dependent under this Plan or the grandchild no longer meets the definition of Children.

The Employee and/or Dependent is responsible for the cost of all benefits which are provided after the date of termination of coverage.

SECTION IX: CLAIMS PROVISIONS

A. **Proof of Loss**

If a Member incurs a charge for which benefits are payable under this Plan as the primary carrier, written proof of such charge must be furnished to Vantage within ninety (90) days after the charge is incurred. Written proof must consist of procedures and diagnoses itemized by the Provider on a claim form or a superbill. When a Member must first file claims with another primary carrier, Vantage being the secondary plan, the explanations of benefits from the primary carrier must be submitted to Vantage within twelve (12) months of the date of service. **Under no circumstance will Vantage consider a claim for payment that is submitted more than twelve (12) months after the date the services were rendered.**

B. **Payment of Claims**

All Vantage approved benefits for services of In-Network Providers must be received from and paid directly to the institution or person rendering the service.

Vantage approved benefits for services of Out-of-Network Providers may be paid directly to the institution or person rendering the service or, if payment by the Member was required at the time of service, may be reimbursed to the Member. Reimbursements to Members will be made only if documentation of procedures are itemized by the provider on a claim form or a superbill submitted to Vantage. Reimbursements are not available for items or services provided by Medicare Opt-Out Physicians. The Medicare opt-out list is available online at https://www.novitas-solutions.com/enrollment/optout/indrx.html. If such benefits are not paid as of the date the Member dies, or if the Member is a minor or is not capable of giving a legally binding receipt for the payment of any benefits, Vantage, at its option, may pay the benefit to:

- the person or institution rendering the service; or
- one or more of the following relatives of the Member: spouse, parent(s), Child(ren), brother(s) or sister(s), the Member's Beneficiary or estate.

Any payments made in this manner will discharge Vantage of its duty to the extent of such payments. Vantage will not be liable as to the application of such payment.

Member may NOT assign benefits to providers. However, Member understands that Participating Providers reserve the ability to directly pursue any third parties who cause accidental injury or Illness to Members for the full amount of the cost of the medical services rendered to Member and forego submitting claims to Vantage for payment. In the event that a Participating Provider elects to pursue a third party recovery and not submit a claim or proof of loss to Vantage, prior written consent of the Member must be obtained and the Member may be responsible for any unpaid Participating Provider charges not compensated by the third parties.

Vantage shall pay claims timely and in accordance with the state law. Electronic clean claims received from all Health Care Providers shall be paid within twenty-five (25) days from date of receipt by Vantage. Non-electronic clean claims received from Participating Providers within forty-five (45) days from the date of service shall be paid within forty-five (45) days from date of receipt by Vantage. Non-electronic clean claims received from Participating Providers after forty-five (45) days from the date of service shall be paid within sixty (60) days of date of receipt by Vantage. All non-electronic clean claims received from Non-Participating Providers shall be paid within thirty (30) days from date of receipt by Vantage.

C. **Examination**

Vantage will have the right, at its own expense, to have a Physician examine any Member whose Illness or injury is the basis of a claim under this Plan. Such examinations will be performed as often as Vantage may reasonably require while a claim is pending.

D. **Authorization to Examine Health Records**

The Member consents to and authorizes any Participating Provider or Out-of-Network Provider of Covered Services to permit the examination and copying of any portion of the Member's Hospital or medical records, when requested by Vantage. Information from medical records of Members and information received from Physicians or Hospitals incident to the Physician-patient relationship or Hospital-patient relationship shall be kept confidential. Processing of related claims may be pended until such information is provided.

E. **Legal Actions**

No action at law or in equity may be brought to recover under this Plan before the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Plan. Under no conditions may any legal action be brought after the expiration of one (1) year after the time written proof of loss is required to be furnished, or prior to completion by the Member of the Appeal and Grievance Procedures under this Plan.

SECTION X: COORDINATION OF BENEFITS

If a Member is entitled to benefits for medical care under two or more plans, including this Plan, the amount of benefits provided under this Plan for that care may be reduced to an amount which, together with the benefits provided under all other plans, will not exceed 100% of the Vantage Allowable of any Covered Services under this Plan. This process is called *Coordination of Benefits*. Member must inform Vantage and any Participating Providers rendering services, if the Member and/or Dependent(s) receive services through Vantage that may be covered by Another Health Plan.

The definition of "Another Health Plan" includes any plan providing medical care benefits under (1) group coverage, or any other arrangement of coverage for individuals in a group other than franchised insurance, or (2) coverage under any governmental plan except Medicaid.

Vantage may, without the consent of any person, release or obtain any information that it deems necessary for determining benefits in accordance with the Coordination of Benefits provision in this Plan. Any person claiming benefits under this Plan will furnish Vantage any information it deems necessary for this purpose. All benefits provided are subject to Coordination of Benefits.

If, at any time, Vantage determines that payments have been made which are in excess of the amount necessary to satisfy the conditions of the Coordination of Benefits provision in this Plan, Vantage will have the right to recover the overpayments.

If payments are made under Another Health Plan, which in accordance with this Coordination of Benefits provision payments should have been made under this Plan, Vantage will have the right to pay any organization making the payments any amount it determines will satisfy the intent of that provision. Amounts so paid will be deemed to be benefits paid under this Plan. Vantage will be discharged from liability under this Plan to the extent of the amounts so paid.

1. If coverage is provided in the manner defined below under Another Health Plan, benefits provided under this Plan and the other health plans might exceed actual medical expenses incurred. If this is the case, the combined benefits payable under this Plan and other health plan(s) will not exceed 100% of the Vantage Allowable.
2. The benefits that would be paid under this Plan in the absence of this provision will be reduced so that the sum of the reduced benefits and all benefits to be paid under all other health plans will not be more than the total of allowable expenses in any Benefit Period. Benefits payable under the other health plans include benefits that would have been paid if the Member had properly claimed such benefits.
3. The benefits of this Plan will not be reduced as noted in item 2 above, if the rules of benefit determination in item 4 below require that the benefits of this Plan be determined prior to the benefits of such other plan.
4. The rules by which the order of benefits is determined are:
    a. The plan that covers the person as an Employee or as the certificate holder is the plan that pays first. This is called the "primary plan." The plan that covers the person as Dependent is the plan that pays second, called the "secondary plan."
    b. If Children are covered as Dependents under the plans of both parents, the primary plan is the plan of the parent whose birthday (excluding year of birth) occurs earlier in a calendar year.
    c. When the parents are separated or divorced: (1) if there is a court decree that establishes financial responsibility for the medical, dental, or other health care expenses with respect to the Child, the benefits are determined to be primary in agreement with the court; or (2) if the parent

with custody has remarried, the plan of the parent with custody is primary, the step-parent's plan is secondary, and the plan of the parent without custody pays third.

d. If the above rules do not establish an order of benefit determination, the plan that has covered the person for the longer period of time shall be primary, with the following exception: the benefits of a plan covering a person who is laid-off or a retired Employee, or a Dependent of such person, shall be determined after the benefits of any other plan covering the person as an Employee.

e. Any plan that does not contain a Coordination of Benefits provision is automatically primary.

SECTION XI: SUBROGATION

Recovery of the Cost of Benefits
If a Member is injured or becomes ill through the act of another person or party or entity and Vantage provides benefits for the injury or Illness, Member is entitled to benefits under this Plan and Vantage shall have the right under this Plan to repayment of the cost of any and all benefits paid on behalf of the Member that are associated with the injury or Illness for which the other person or entity is liable.

Subrogation
Subrogation means that Vantage can regain by legal action, if necessary, the cost of benefits paid by Vantage from any person or entity against whom the Member may have a claim. Subrogation will result in savings for the benefit of all Vantage Plan Members because the cost of treatment for sickness or injury will be paid by the persons or entities that are legally responsible for such payment. In the event that benefits are provided under this Plan, Vantage shall be subrogated to the Member's rights of recovery against any person or entity to the extent of the amount of the benefits provided. This includes Vantage's right to bring suit against the person or entity in Vantage's name or the name of the Member. At Vantage's request, the Member shall execute and deliver the necessary documentation (as determined by Vantage) to secure and protect Vantage's subrogation rights. The Member agrees to cooperate with Vantage and/or representatives of Vantage, including its attorneys, in completing such forms and in giving such documentation and information surrounding any Accident or incident the Member was involved in, as Vantage or its representatives deem necessary to fully investigate the Accident or incident. Members also have the following obligations under this subrogation provision:

- To notify Vantage within thirty (30) days of any event which could result in legal action, a claim by or against a third party, or a claim against the Member's own insurance.
- To seek recovery from the responsible person or entity (or his/her insurer) of all amounts in connection with benefits paid by Vantage under this Plan and to notify Vantage within ten (10) business days of any such actions taken by the Member.
- To refrain from doing anything to impair, prejudice or discharge Vantage's rights of subrogation.
- To fully cooperate and assist Vantage, as is deemed necessary by Vantage, to enforce Vantage's rights of subrogation. This obligation to assist Vantage will apply to Member's legal representative.
- To notify Vantage of and pay to Vantage any amounts received by Member or Member's legal representative to the extent of the cost of the benefits provided by Vantage to which Vantage is entitled to because of its rights of subrogation.

Reimbursement
Vantage has the right to be reimbursed by its Members the cost of any and all benefits that were paid by Vantage that are associated with the Member's injury or Illness caused by another person or entity. This right of reimbursement will apply where Vantage has paid benefits and the Member and/or the Member's representative has been reimbursed any amounts by another person or entity or by any other source as set forth below. If a Member, or any other person or entity on the Member's behalf, that has been paid, does not properly refund the full amount to Vantage for the cost of benefits paid by Vantage, Vantage may reduce the amount of any future benefits that are payable for the Member under this Plan. Vantage's right of reimbursement as to a Member is limited, however, to the extent of the actual cost of the benefits provided by Vantage.

Lien
Vantage, by paying any benefits under this Plan, is granted a lien on the proceeds of any settlement, judgment or other payment received by the Member. The Member hereby consents to Vantage's lien and agrees to take whatever steps are necessary to assist Vantage in securing its lien.

Assignment
Vantage, by the payment of any benefits under this Plan, is granted an assignment of the proceeds of any settlement, judgment or other payment received by the Member to the extent of the benefits paid. By accepting benefits hereunder, the Member consents to Vantage's assignment and authorizes and directs his or her attorney, personal representative or any insurance company to directly reimburse Vantage or its designee to the extent of the cost of the benefits paid. Any such assignment is effective and binding upon the Member's attorney, personal representative or any insurance company upon notice of this provision.

Participating Providers' Subrogation Rights
Participating Providers have a contractual right to pursue third parties for the full recovery of the cost of the medical services rendered to Member in lieu of submitting claims to Vantage for payment. In such an instance, and with the written consent of the Member, Participating Providers may request appropriate information from the Member regarding the third parties responsible for the injury or Illness of the Member, and Member shall cooperate in providing this information to Participating Providers. Participating Providers who elect to pursue third parties for a recovery will not, under any circumstances submit their claims to Vantage for payment, but will only pursue the third parties for recovery. In such an event, and if full recovery is not made by the Participating Providers, Member understands that he or she may have a further financial responsibility to Participating Providers for the cost of medical services not recovered from the third parties.

Other Vantage Rights
The subrogation and reimbursement rights of Vantage, including the foregoing right of assignment, is applicable to any recoveries made by, or on behalf of, the Member as a result of the injuries or Illnesses sustained including, but not limited to, the following sources:

- Payments made directly by the tortfeasor or any insurance company on behalf of the tortfeasor or any other payments on behalf of the tortfeasor.
- Any payments, settlements, judgment or arbitration awards paid by any insurance company under an uninsured or underinsured motorists coverage policy, whether on behalf of a Member or other person.
- Any workers' compensation award or settlement.
- Medical payments coverage under any automobile insurance policy.
- Premises or homeowners insurance coverage including premises or homeowners medical payments coverage.
- Any other payments from any other source designed or intended to compensate a Member for injuries sustained as a result of negligence or alleged negligence of any person or entity.

Vantage's right to recover, whether by subrogation or reimbursement, shall also apply to the Member's Dependents and minor Children, whether or not adjudged incompetent or disabled, heirs, and any settlement or recovery attributable thereto.

To the extent not preempted by federal law, Vantage will not attempt to subrogate until the Member is made whole and Vantage will pay its portion of attorney's fees therewith. No Member shall enter into any type of settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the cost of benefits provided by Vantage. Vantage's recovery rights shall not be defeated or impaired in any respect by an allocation of settlement proceeds exclusively to non-medical expense damages.

Further, no Member shall incur any expenses on behalf of Vantage in pursuit of Vantage's rights hereunder.

Vantage shall recover the full amount of benefits provided under this Plan without regard to any claim of fault on the part of any Member, whether by comparative negligence or otherwise. Benefits payable by Vantage under this Plan are secondary to any coverage under no fault or similar insurance.

In the event that a Member fails or refuses to comply with the terms of this Plan and this provision specifically, the Member shall reimburse Vantage for any and all costs and expenses including attorney fees incurred by Vantage in enforcing its rights hereunder. Further, the failure of any Member to comply and/or assist Vantage with its subrogation rights may result in termination of the Member's participation in this Plan and the Member shall be responsible for the cost of all benefits and services paid by Vantage related to the injury.

SECTION XII: APPEAL & GRIEVANCE PROCEDURES

Vantage recognizes its responsibility to provide Members with adequate methods to make inquiries and express concerns with Vantage and any Health Care Provider. Members are encouraged to contact Vantage Member Services for assistance with complaints or suggestions concerning the Plan.

Member Services is available Monday through Friday from 8:00 a.m. to 8:00 p.m. by calling:

(318) 361-0900
Toll-free (888) 823-1910 Ext. 1

What is the difference between an Appeal and Grievance?
As a Member of this Plan, you have the right to file a complaint if you have concerns related to your coverage. The two types of complaints you can file are *Appeals* and *Grievances*.

An Appeal is the type of complaint you file when you want Vantage to reconsider and change a decision related to Covered Services, (including a denial of, reduction in, or termination of a Covered Service or a failure to make a payment in whole or in part for a Covered Service) or a rescission of coverage under this Plan. *Examples of Appeals*: If you disagree when Vantage will not pay for services, you may file an Appeal. If Vantage or a Participating Provider refuses to provide a service you think should be covered, you may file an Appeal. If Vantage or a Health Care Provider terminates or reduces services you have been receiving, you may file an Appeal.

A Grievance is the type of complaint you file if you have any *other concerns* related to Vantage or a Health Care Provider. *Examples of a Grievance*: If you have concerns related to the quality of your care, you may file a Grievance. If you experience unpleasant attitudes or behavior at a Health Care Provider, you may file a Grievance. Other issues for which you may file a Grievance include lengthy wait times in a Health Care Provider's facility, difficulty getting an appointment or contacting a Health Care Provider, and any concerns or difficulty you encounter when contacting Vantage or communicating with a Vantage employee.

Members always have the right to file a complaint with the Louisiana Department of Insurance.

APPEALS PROCEDURE
Any Member that wishes to file an Appeal should call Member Services. The Vantage Member Services Representative will explain the Appeals process and frequently the complaint can be resolved during the call. If the Member's complaint is resolved, a copy of the contact report detailing the circumstances, description of the findings, and the resolutions will be placed in the Member's file. Member Services may be reached at (318) 361-0900 or (888) 823-1910.

First Level Internal Appeal
If the Member Services Representative is unable to resolve the issue to the Member's satisfaction, the Member may file a formal Appeal. A formal Appeal must be written and must be mailed or hand-delivered to:

Vantage Health Plan, Inc.
Attn: MNRO-Medical Director
130 DeSiard Street, Suite 300
Monroe, LA 71201

The Member Services Representative will instruct the Member to include the following information with the Appeal:

- Member's name, address and Plan identification number
- A copy of the initial denial notice
- A summary of the reason for the Appeal

- A description of the solution desired by the Member
- Signature of the Member or authorized representative

For the complaint to be considered as a formal Appeal, it must be submitted in writing by the Member within one hundred eighty (180) days from the date of the initial decision to deny a benefit in whole or in part. The Appeal will be forwarded to the Vantage Medical Director and will be adjudicated in a manner designed to ensure independence and impartiality without regard to the initial denial. The Medical Director will review the Appeal letter and information related to the Appeal. If any evidence generated by Vantage is utilized in connection with the Appeal to which the Member does not have access, Vantage may make that information available to the Member and allow the Member to review and respond to that information prior to a decision being rendered. The Medical Director will determine the resolution for the Appeal and respond in writing to the Member within thirty (30) working days of receiving the Appeal as detailed below, unless the Member or the Member's authorized representative has agreed to an extension. If additional information is required to address the Appeal, the determination period will be tolled after we have notified you in writing that additional information is required to complete the review, and will resume on the date that the requested information is received.

Appeals are classified as follows:

- **Expedited Appeals**: A determination will be rendered within seventy-two (72) hours of receiving the Appeal or as quickly as the Member's health requires, unless the Member or the Member's authorized representative and Health Care Provider fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under this Plan. These determinations are for situations where the 1) Member's life or health would otherwise be jeopardized; or 2) the ability of the Member to regain maximum function could be jeopardized; or 3) in the opinion of a Physician with knowledge of the Member's medical condition, a non-urgent care determination would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
- **Prospective Appeals**: A determination will be rendered within fifteen (15) days of receiving the Appeal when services have not yet been provided.
- **Retrospective Appeals**: A determination will be rendered within thirty (30) days of receiving the Appeal, but not more than one-hundred and eighty (180) calendar days from the date of service. Retrospective Appeals are reviews of Medical Necessity conducted after services have been provided to a Member.

Second Level Review

Should the Member decline to accept an adverse First Level Internal Appeal decision, the Member will be allowed to Appeal this decision in writing, provided this Second Level Review involves matters of medical necessity. The Member must file a formal written Appeal to the Utilization Review/Appeals Committee within sixty (60) days of the adverse First Level Internal Appeal decision. This Appeal can be mailed or hand-delivered to:

Vantage Health Plan, Inc.,
Attn: Utilization Review/Appeals Committee
130 DeSiard Street, Suite 300
Monroe, LA 71201

The Utilization Review/Appeals Committee will review all the information submitted by the Member and documented by the Member Services Representative and Medical Management Nurse. The Utilization Review/Appeals Committee shall hold the review meeting within forty-five (45) days of receiving the formal Appeal.

The Member shall be notified in writing at least fifteen (15) days in advance of the review date of the right to attend the review, present his or her case to the review panel, submit supporting materials, testify or ask questions of any representative of the Utilization Review/Appeals Committee.

The Member will be notified in writing of the Utilization Review/Appeals Committee decision within five (5) days of completing the review.

Standard External Review

The Member, with the concurrence of the treating Health Care Provider, may file a request with Vantage for an external review for Medical Necessity if the request is made within one hundred eighty (180) days after the date of receipt of a notice of a Second Level Review adverse determination. Within seven (7) days after the date of receipt of the request for an external review, Vantage shall provide the documents and any information used in making the Second Level Appeal adverse determination to its designated Independent Review Organization (IRO). The IRO shall review all information and documents received and any other information submitted in writing by the Member or the Member's Health Care Provider.

The IRO shall provide notice of its recommendation to Vantage, the Member or the Member's authorized representative and the Member's Health Care Provider within thirty (30) days after the date of receipt of the second level determination information subject to an external review, unless all parties agree to a longer period. External review decisions are binding on the MNRO and on the covered Member for purposes of determining coverage under this Plan that requires a determination of Medical Necessity.

Expedited Appeals Process

In the event of an adverse determination regarding Medical Necessity, an Expedited Appeal may be requested for situations in which the time frame of a non-urgent care determination could 1) seriously jeopardize the life or health of the Member; or 2) jeopardize the ability of the Member to regain maximum function; or 3) in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

An Expedited Appeal may be initiated by the Member, with the consent of the treating Health Care Provider, or by the Health Care Provider acting on behalf of the Member.

An Expedited Appeal shall be provided for any request concerning a prospective (pre-service) admission, availability of care, continued stay, or health care service for a Member who has received Emergency services but has not been discharged from a facility. Expedited Appeals are not available for retrospective determinations. All necessary information, including Vantage's decision, shall be transmitted between Vantage and the Member, or the Member's authorized representative, or the Health Care Provider acting on behalf of the Member by telephone, facsimile, or any other available expedited method.

Vantage shall make a decision and notify the Member or the Health Care Provider acting on behalf of the Member as expeditiously as the Member's medical condition requires, but in no event more than seventy-two (72) hours after the Appeal is received, unless the Member or the Member's authorized representative and Health Care Provider fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under this Plan. Vantage shall provide written confirmation of its decision concerning an Expedited Appeal within three (3) working days.

GRIEVANCE PROCEDURE

Vantage has established an administrative Grievance resolution procedure to provide a full and fair review of Grievances and to assist Members in resolving those Grievances to their satisfaction. This procedure is intended to provide prompt consideration of Member Grievances at the appropriate decision making levels of Vantage. **Grievances for dates of service greater than twelve (12) months from the date the Grievance is filed will not be considered**. **Members must follow the procedures set forth below in the event a Grievance arises under this Agreement. Members are required to follow the Appeal Procedures if the complaint is to request that Vantage reconsider and change a decision related to Covered Services, (including a denial of, reduction in, or termination of a Covered Service or a failure to make a payment in whole or in part for a Covered Service) or a rescission of coverage under this Plan.**

This Grievance Procedure has been established to assure that every Member will receive a timely response to any complaint and/or formal Grievance, if appropriate. Ultimate discretionary authority to interpret the Vantage Plan and to make final determinations as to the appropriate resolution of complaints shall be vested in Vantage.

Members are required to fully complete the Grievance Procedure prior to bringing any legal action or proceeding against Vantage. Failure to fully complete the Grievance Procedure will cause the legal action or proceeding to be premature. Moreover, any legal action or proceeding against Vantage must be brought within one (1) year from the incident which gives rise to the complaint, or else the Member forfeits his or her right to bring any legal action or proceeding against Vantage.

Step 1: Informal and Formal Grievances
The Member Services department will assist the Member in trying to resolve the matter on an informal basis. If this is not successful, the Member may file a formal Grievance. A complaint or inquiry is not considered a "formal Grievance" until Vantage receives written documentation addressing the matter from the Member.

Step 2: Reconsideration of Grievance Determination
Should a Member decline to accept the resolution proposed by Vantage, the Member will be informed that he/she may ask in writing for the Vantage Appeals and Grievances Committee to review the Grievance. The Member must send, within thirty (30) days after receipt of the response, the formal written Grievance to the Vantage Appeals and Grievances Committee. This can be mailed or hand-delivered to:

Vantage Health Plan, Inc.
Vantage Appeals and Grievances Committee
130 DeSiard Street, Suite 300
Monroe, LA 71201

The Vantage Appeals and Grievances Committee will review all the information submitted by the Member and documented by the Member Services Representative and /or Medical Management Nurse. The Member will be notified, in writing, regarding the decision of the Vantage Appeals and Grievances Committee within sixty (60) days from the date the Member files the formal written Grievance.

The Member must fully cooperate with Vantage in its effort to promptly resolve any Grievance. In the event the Member does not fully cooperate with Vantage, the Member will be deemed to have waived his or her right to have the Grievance processed within the time frames set forth above. The time frames set forth herein may be modified by the written mutual consent of Vantage and the Member.

Section XIII: COBRA Notice

GENERAL NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction
This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of Group Health Plan coverage under certain circumstances when coverage would otherwise end under this Plan offered through the Office of Group Benefits. **This notice generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice supersedes all other Initial/General COBRA Notices provided to you.** COBRA (and the description of COBRA coverage contained in this notice) applies only to the Group Health Plan benefits offered under the Plan and not to any other benefits offered by the State of Louisiana (such as life insurance).
The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your Group Health Plan coverage. It can also become available to your spouse and Dependent Children, if they are covered under the Plan, when they would otherwise lose their Group Health Plan coverage. The Plan provides no greater rights than what COBRA requires—nothing in this notice is intended to expand your rights beyond COBRA's requirements.

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

Who Is Entitled to Elect COBRA Coverage?
If you are an Employee, you will be entitled to elect COBRA coverage if you lose your Group Health Plan coverage because either one of the following qualifying events happens:

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

If you are the spouse of an Employee, you will be entitled to elect COBRA coverage if you lose your Group Health Plan coverage because any of the following qualifying events happens:

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

A person enrolled as the Employee's Dependent Child will be entitled to elect COBRA if he or she loses Group Health Plan coverage because any of the following qualifying events happens:

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

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

Vantage is not responsible for issuing continuation coverage notices or providing continuation coverage election forms to Employees. This responsibility is solely the Employer's. Generally, Employers may provide a continuation coverage election form to Employees through the Employer's human resources department, on their website, or at the time of termination.

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

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

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

Continuation coverage shall also be available for a surviving spouse 50 years of age or older. Surviving spouses may elect continuation coverage for a period of ninety (90) days following termination of coverage. Coverage for the surviving spouse terminates upon failure to timely pay the premium, if the surviving spouse remarries, or if the surviving spouse becomes eligible to enroll in Medicare or another health plan.

How Long Does COBRA Coverage Last?

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

Extension of COBRA Coverage
The COBRA coverage periods described above are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage periods described in this notice as described in this Plan Certificate. There are two ways in which the period of COBRA coverage resulting from a termination of employment or reduction of hours can be extended.

Disability extension of COBRA coverage
If a qualified Beneficiary is determined by the Social Security Administration (or by the staff of the Office of Group Benefits in the case of a person who is ineligible for Social Security disability benefits due to insufficient "quarters" of employment) to be disabled on the date the Covered Person became eligible for continued coverage or within the initial 18 months of coverage, and you notify the Office of Group Benefits in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered Employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered Employee's termination of employment and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). For persons eligible to receive Social Security disability benefits, the disability extension is available only if you notify the Office of Group Benefits in writing and submit a copy of the Social Security Administration's determination of disability within 60 days after the latest of the date of the Social Security Administration's disability determination and the date on which the qualified Beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered Employee's termination of employment or reduction of hours.

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

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

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

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

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

In providing this notice, you must use OGB's form, entitled "Notice of Second Qualifying Event Form," (you may obtain a copy of this form from the Office of Group Benefits at no charge, or you can download the form at www.groupbenefits.org), **and you must follow the procedures specified in the box at the end of this notice entitled "Notice Procedures." If these procedures are not followed or if the notice is not provided in writing to the Office of Group Benefits within the 60-day notice period, THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.**

More Information About Individuals Who May Be Qualified Beneficiaries

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

Alternate recipients under QMCSOs
A Child of the covered Employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Office of Group Benefits during the covered Employee's period of employment with the Participant Employer is entitled to the same rights to elect COBRA as an eligible Dependent Child of the covered Employee.

COBRA Premium Reduction
The American Recovery and Reinvestment Act of 2009 (ARRA), as amended by the Department of Defense Appropriations Act (2010 DOD Act) on December 19, 2009, the Temporary Extension Act of 2010 (TEA) on March 2, 2010 and the Continuing Extension Act of 2010, which was signed into law on April 15, 2010, provides for premium reductions for health benefits under COBRA. Eligible

individuals pay only 35 percent of their COBRA premiums; the remaining 65 percent is reimbursed to the coverage provider through a tax credit.

Changes Regarding COBRA Continuation Coverage under ARRA, as amended by the Continuing Extension Act of 2010

- The COBRA premium subsidy eligibility period has been extended to May 31, 2010. Those eligible for the subsidy (Assistance Eligible Individuals) are COBRA qualified beneficiaries whose COBRA qualifying event is/was loss of health coverage due to involuntary termination of employment occurring on or after September 1, 2008, but not later than May 31, 2010.
- The maximum period for which the COBRA premium subsidy is available remains at 15 months.
- The subsidy applies to COBRA premiums for both Employees and Dependents.

IMPORTANT

- If, after you elect COBRA and while you are paying the reduced premium, you become eligible for other Group Health Plan coverage or Medicare you MUST notify the plan in writing. If you do not, you may be subject to a tax penalty.
- Electing the premium reduction disqualifies you for the Health Coverage Tax Credit. If you are eligible for the Health Coverage Tax Credit, which could be more valuable than the premium reduction, you will have received a notification from the IRS.
- The amount of the premium reduction is recaptured for certain high income individuals. If the amount you earn for the year is more than $125,000 (or $250,000 for married couples filing a joint Federal income tax return) all or part of the premium reduction may be recaptured by an increase in your income tax liability for the year. If you think that your income may exceed the amounts above, you may wish to consider waiving your right to the premium reduction. For more information, consult your tax preparer or visit the IRS webpage on ARRA at www.irs.gov.

If you have any questions, please contact the OGB Customer Service department at 800-272-8451. For more information, please click on the following link to the Department of Labor's Fact Sheet: COBRA Premium Reduction.

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

COBRA Notice Procedures

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

Notice Must Be Written and Submitted on Plan Forms: Any notice that you provide must be in writing and must be submitted on OGB's required form (OGB's required forms are described above

this notice, and you may obtain copies from the Office of Group Benefits without charge or download them at www.groupbenefits.org. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable.

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

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

Office Phone: 800-272-8451

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

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

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

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

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

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

SECTION XIV: WHCRA NOTICE

Women's Health and Cancer Rights Act of 1998 Notice
For Vantage Health Plan Members receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

These benefits are subject to authorizations, Co-payments, and/or Co-insurance that are applicable to your medical and surgical benefits provided under this Plan.

Vantage Health Plan, Inc. is a Louisiana domiciled HMO subject to licensing and regulatory requirements of the Louisiana Department of Insurance and the laws of the State of Louisiana. Pursuant to Louisiana R.S. 22:272(E), **"**Coverage for reconstructive surgery shall only be required if the reconstructive surgery is performed under the same policy or plan under which the mastectomy was performed**."** If you would like more information on WHCRA benefits, call the Vantage Member Services department at (318) 361-0900 or (888) 823-1910.

SECTION XV: HIPAA NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

At Vantage Health Plan, Inc. (Vantage), we respect the confidentiality of your health information and will protect it in a responsible and professional manner. We consider this information private and confidential and have policies and procedures in place to protect the information against unlawful use and disclosure.

This notice describes what types of information we collect, explains when and to whom we may disclose it, and provides you with additional important information. Vantage is allowed by law to use and disclose your health information to carry out the operations of our business. We are required by law to maintain the privacy of your health information, to provide you with this notice and abide by the notice in effect. It also informs you of your rights with respect to your health information and how you can exercise those rights.

What is Protected Health Information or PHI?
When we talk about "information" or "health information" in this notice we mean Protected Health Information or PHI. PHI is information that identifies an individual enrolled in a Vantage benefit Plan. It relates to the person's participation in the Plan, the person's physical or mental health or condition, the provision of health care to that person, or payment for the provision of health care to that person. It does not include publicly available information, or information that is available or reported in a summarized fashion that does not identify any individual person.

What types of personal information does Vantage collect?
Like all health benefits companies, we collect the following types of information about you and your Dependents:

- Information we receive directly or indirectly from you or OGB or third party administrator through applications, surveys, or other forms, in writing, in person, by telephone, or electronically, including our web site (e.g., name, address, social security number, date of birth, marital status, Dependent information, employment information, medical history).
- Information about your relationship and transactions with us, our affiliates, our providers, our agents, and others (e.g., health care claims and encounters, medical history, eligibility information, payment information, service request, and Appeal and Grievance information).

How does Vantage protect this information?
Vantage has policies that limit internal and external sharing of PHI to only persons who have a need for it to provide benefit services to you and your Dependents. We maintain physical, electronic and procedural safeguards to protect PHI against unauthorized access and use. For example, access to our facilities is limited to authorized personnel and we protect information electronically through a variety of technical tools. We also have established a Privacy Committee, which has overall responsibility for the development, implementation, training, oversight and enforcement of policies and procedures to safeguard PHI against inappropriate access, use and disclosure, consistent with applicable law.

How may Vantage use or share your information?
To effectively operate your health benefit Plan, Vantage may use and share PHI about you to:

- Perform our duties of certificate of insurance, which may involve claims review and payment or denial; coordination of benefits; Utilization Review; Medical Necessity review; coordination of care; response to Member inquiries or requests for services; conduct of Grievance, Appeals, and external review programs; benefits and program analysis and reporting; risk management;

detection and investigation of fraud and other unlawful conduct; auditing; underwriting; administration and coordination of reinsurance contracts.

- Operate preventive health programs, disease early detection programs, disease management programs and case management programs in which we or our affiliates or contractors send educational materials and screening reminders to eligible Members and providers; perform health risk assessments; identify and contact Members who may benefit from participation in disease or case management programs; and send relevant information to those Members who enroll in the programs, and their providers.
- Conduct quality improvement activities, such as the credentialing of Participating network providers; and accreditation by the National Committee for Quality Assurance (NCQA), Centers for Medicare & Medicaid Services (CMS), and/or other independent organizations, where applicable.
- Conduct performance measurement and outcomes assessment; health claims analysis and reporting.
- Provide data to outside contractors who help us conduct our business operations. **We will not share your PHI with these outside contractors unless they agree in writing to keep it protected.**
- Manage data and information systems.
- Perform mandatory licensing, regulatory compliance/reporting, and public health activities; responding to requests for information from regulatory authorities, responding to government agency or court subpoenas as required by law, reporting suspected or actual fraud or other criminal activity; conducting litigation, arbitration, or similar dispute resolution proceedings; and performing third-party liability and subrogation activities.
- Change policies or contracts from and to other insurers, HMOs, or third party administrators.
- Provide data to the Employer that sponsors the benefit Plan through which you receive health benefits. **We will not share your PHI with OGB or third party administrator except for deidentified summary health information, enrollment and disenrollment information, specific information authorized by you and any information necessary to administer the Plan.**

We consider the activities described above as essential for the operation of our health Plan. For example Vantage may feature:

- Cancer screening reminder programs that promote early detection of breast, ovarian, and colorectal cancer, when these Illnesses are most treatable.
- Disease management programs that help Members work with their Physicians to effectively manage chronic conditions like asthma, diabetes, and heart disease to improve quality of life and avoid preventable emergencies and hospitalizations.
- Quality assessment programs that help us review and improve the services we provide.
- A variety of outreach programs that help us educate Members about the programs and services that are available to them, and let Members know how they can make the most of their health benefits.

There are also state and federal laws that may require us to release your health information to others. We may be required to provide information as follows:

- To state and federal agencies that regulate us such as the US Department of Health and Human Services and the Louisiana Department of Insurance.
- For public health activities. For example, we may report information to the Food and Drug Administration for investigating or tracking of Prescription Drug and medical device problems.
- To public health agencies if we believe there is a serious health or safety threat.
- With a health oversight agency for certain oversight activities (for example, audits, inspections, licensure, and disciplinary actions.)

- To a court or administrative agency (for example, pursuant to a court order, search warrant or subpoena).
- For law enforcement purposes. For example, we may give information to a law enforcement official for purposes of identifying or locating a suspect, fugitive, material witness or missing person.
- To a government authority regarding child abuse, neglect or domestic violence.
- To a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also share information with funeral directors as necessary to carry out their duties.
- For procurement, banking or transplantation of organs, eyes or tissue.
- To specialized government functions, such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- For on the job-related injuries because of requirements of state worker compensation laws.

Vantage does not share PHI for any purpose other than those listed above. If one of the above reasons does not apply, **we must get your written authorization to use or disclose your health information**. In the event that you are unable to provide the authorization (for example, if the Member is medically unable to give consent), we accept authorization from any person legally authorized to give consent on behalf of the Member, such as a parent or guardian. If you give us written authorization and change your mind you may revoke your written authorization at any time.

What are your rights?
The following are your rights with respect to your PHI. If you would like to exercise any of these rights, please contact Vantage at the address or phone numbers listed at the end of this notice. We will require that you make your request in writing and will provide you with the appropriate forms.

You have the right to inspect and/or obtain a copy or summary of information that Vantage maintains about you in your designated record set. A "designated record set" is a group of records maintained by or for Vantage that are your enrollment, payment, claims determination, and case or medical management records or a group of records, used in whole or in part, by Vantage to make decisions about you, such as Appeal and Grievance records. Vantage may charge you a reasonable administrative fee for copying, postage or summary preparation depending on your specific request.

However, you do not have the right to inspect certain types of information and we can not provide you with copies of the following information:

- contained in psychotherapy notes;
- compiled in reasonable anticipation of, or for use in a civil criminal or administrative action or proceeding; or
- subject to certain federal laws governing biological products and clinical laboratories.

We will respond to your request no later than 30 days after we receive it or if the information requested is not accessible or maintained on site, no later than 60 days after we receive it.

Additionally, in certain other situations, we may deny your request to inspect or obtain a copy of your information. If we deny your request, we will notify you in writing and may provide you with a right to have the denial reviewed.

You have the right to ask us to amend information we maintain about you in your designated record set. We will require that your request be in writing and that you provide a reason for your request. We will respond to your request no later than 60 days after we receive it. If we are unable to act within 60 days, we may extend that time by no more than an additional 30 days. If we need to extend this time, we will notify you of the delay and the date by which we will complete action on your request.

If we make the amendment, we will notify you that it was made. In addition, we will provide the amendment to any person that we know has received your health information. We will also provide the amendment to other persons identified by you.

If we deny your request to amend, we will notify you in writing of the reason for the denial. The denial will explain your right to file a written statement of disagreement. We have a right to dispute your statement. However, you have the right to request that your written request, our written denial and your statement of disagreement be included with your information for any future disclosures.

NOTE: If you want to access or amend information about yourself, you should first go to your provider (e.g., doctor, pharmacy, Hospital or other caregiver) that generated the original records, which are more complete than any we may maintain.

You have the right to receive an accounting of certain disclosures of your information made by us during the six years prior to your request. Please note that we are not required to provide you with an accounting of the following information:

- Any information collected prior to April 14, 2003.
- Information disclosed or used for treatment, payment, and health care operations purposes.
- Information disclosed to you or pursuant to your authorization;
- Information that is incident to a use or disclosure otherwise permitted.
- Information disclosed for a facility's directory or to persons involved in your care or other notification purposes;
- Information disclosed for national security or intelligence purposes;
- Information disclosed to correctional institutions, law enforcement officials or health oversight agencies;
- Information that was disclosed or used as part of a limited data set for research, public health, or health care operations purposes.

We will act on your request for an accounting within 60 days. We may need additional time to act on your request, and therefore may take up to an additional 30 days. Your first accounting will be free, and we will continue to provide to you one free accounting upon request every 12 months. However, if you request an additional accounting within 12 months of receiving your free accounting, we may charge you a fee. We will inform you in advance of the fee and provide you with an opportunity to withdraw or modify your request.

You have the right to ask us to restrict how we use or disclose your information for treatment, payment, or health care operations. You also have the right to ask us to restrict information that we have been asked to give to family members or to others who are involved in your health care or payment for your health care.

You have the right to ask to receive confidential communications of information, if you believe that you would be harmed if we send your information to your current mailing address. For example, in situations involving domestic disputes or violence, you can ask us to send the information by alternative means (for example by fax) or to an alternative address. We will try to accommodate a reasonable request made by you.

What does Vantage Health Plan, Inc. do with Member PHI when the Member is no longer enrolled in a Vantage Plan?

Vantage Health Plan, Inc. does not destroy PHI when individuals terminate their coverage. The information is necessary and used for many purposes as described in this document, even after the

individual leaves a plan. However, the policies and procedures that protect that information against inappropriate use and disclosure apply regardless of the status of any individual Member. In many cases, PHI is subject to legal retention requirements, and after that requirement for record maintenance, PHI is destroyed in a confidential process.

Exercising your rights:

- **You have a right to receive a copy of this notice upon request at any time**. We provide this notice to Members upon enrollment in a Vantage Plan. You can also view a copy of the notice on our web site at www.VHP-stategroup.com. Should any of our privacy practices change, **we reserve the right to change the terms of this notice and to make the new notice effective for all protected health information that we maintain**. Once revised, we will provide the new notice to you and post it on our web site.
- If you have any questions about this notice or about how we use or share information, please write to the Vantage Privacy Officer or contact the Vantage Member Services department at the address and phone numbers listed at the end of this notice.

If you are concerned that your privacy rights may have been violated, you may file a complaint with Vantage. You also have the right to complain to the Secretary of the U.S. Department of Health and Human Services. If you have any questions about the complaint process, including the address of the Secretary of Health and Human Services, please write to Vantage's Privacy Officer or contact Vantage's Member Services department at the address and phone numbers listed at the end of this notice.

Vantage will not take any action against you for filing a complaint. This notice is effective April 14, 2003. Contact Information for Questions or Complaints Regarding Privacy:

Mailing Address
Vantage Health Plan, Inc.
ATTENTION: Privacy Officer
130 DeSiard Street, Suite 300
Monroe, LA 71201
E-mail: Privacy.Officer@vhpla.com

Questions
Member Services Department
(318) 361-0900
(888) 823-1910

VANTAGE HEALTH PLAN, INC.
Making Healthcare Work!

CORPORATE LOCATION:

130 DeSiard Street, Suite 300
Monroe, LA 71201

Phone: (318) 361-0900
Toll-Free: (888) 823-1910
Fax: (318) 361-2159

SHREVEPORT LOCATION:

855 Pierremont Rd., Suite 109
Shreveport, LA 71106

Phone: (318) 678-0008
Toll-Free: (888) 823-1910
Fax: (318) 361-2194