MEMBER

CERTIFICATE OF COVERAGE

Vantage Medical Home HMO

Office of Group Benefits

VANTAGE HEALTH PLAN

2022

Vantage Health Plan

A

HEALTH MAINTENANCE ORGANIZATION

OPERATED BY

Vantage Health Plan, Inc.
130 DeSiard Street, Suite 300
Monroe, LA 71201
(318) 998-4371 or (844) 833-7504
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" or "Vantage Health Plan").

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

This Plan's coverage will begin at 12:01 AM (Central Time) on the effective date and end at 11:59 PM (Central Time) on the last day of the Benefit Period.

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. 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. However, Balance-Billing by Out-of-Network Providers is prohibited in certain situations. This includes all Out-of-Network Emergency Medical Services as well as certain ancillary services provided by Out-of-Network Providers in a non-Emergency setting at an In-Network facility. You cannot be Balance-Billed for these services. The Cost Share for these Out-of-Network Covered Services will be used to meet your In-Network Medical Deductible and In-Network Out-of-Pocket Maximum.

HEALTH CARE SERVICES MAY BE PROVIDED TO YOU AT A PARTICIPATING HEALTH CARE FACILITY BY FACILITY-BASED PHYSICIANS WHO ARE NOT IN YOUR HEALTH 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 COST SHARE AND NON-COVERED SERVICES. SPECIFIC INFORMATION ABOUT IN-NETWORK AND OUT-OF-NETWORK FACILITY-BASED PHYSICIANS CAN BE FOUND BY CALLING MEMBER SERVICES OR ONLINE AT *www.VantageHealthPlan.com/Provider/ParNonParSearch*.

If you need additional information, please contact Vantage Health Plan, Inc., 130 DeSiard St., Ste. 300, Monroe, LA 71201 or by calling (318) 998-4371 or toll-free (844) 833-7504. 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 any Member who is deaf or hard of hearing, please call teletypewriter (TTY) services at 711. Vantage offers some language translation, sign language and 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 Medical Home 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 as well as the rights and obligations of both parties. Any service not listed as a Covered Service is not covered. If you or Vantage fails to enforce any provision of this contract, it will not be considered a waiver of the provision or any other provisions in the future.

COST SHARE SCHEDULE
The Cost Share Schedule (enclosed with this Certificate) details the Deductible, Co-payment, and Co-insurance amounts or percentages that are your financial responsibility and are based on the type of Covered Service and the Provider network. 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 any Deductible or to the Initial In-Network Medical or PPACA In-Network Out-of-Pocket Maximums.

Your Plan offers lower Cost Share for certain Covered Services if such services are performed by Affinity Health Network (AHN) Providers. See enclosed Cost Share Schedule.

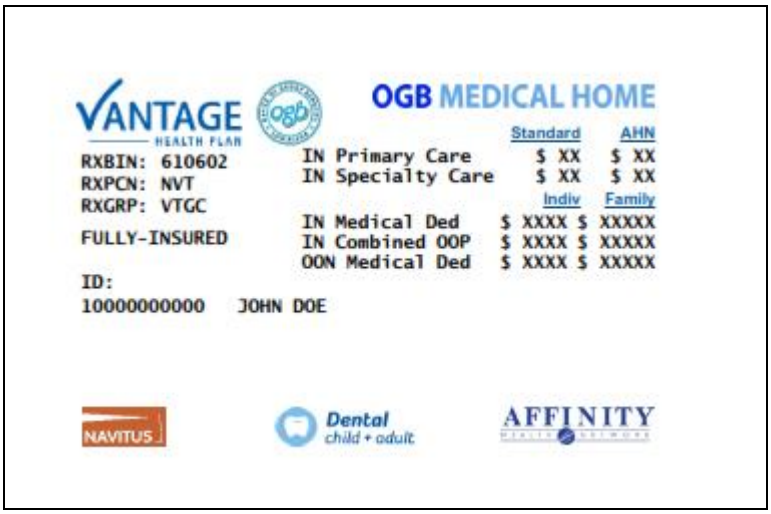
IDENTIFICATION CARDS
The Vantage identification card (Member ID Card) is to be shown each time you or your covered Dependents receive services at a Physician's office, Hospital, other Provider or pharmacy. Not showing your Member ID Card could result in bills being sent to you instead of to Vantage. Your Member ID Cards for the upcoming Benefit Period will be mailed to you prior to your Effective Date of coverage.

Your Member ID Card includes the Affinity Health Network logo. **This means your Cost Share will be lower when you receive certain Covered Services from Affinity Health Network (AHN) Providers**. Services with reduced Cost Share are shown on your Member ID Card and/or the Cost Share Schedule. The AHN Providers are listed on the Affinity Health Network pages in the first section of the Provider Directory and on our website, *www.VHP-StateGroup*.

A sample image of the Member ID Card is shown on the following page.

SAMPLE MEMBER ID CARD

FRONT OF ID CARD



BACK OF ID CARD

Prescription Drug information for your pharmacist is located in the top left corner on the front of your Member ID Card.

Each Member's unique Member ID number is located on the front of the Member ID Card next to the Member's name. Additional Member listings may also be located on the back of the Member ID Card for policies with many Dependents.

The information shown on your Member ID Card is as follows:

- **IN Primary Care** – This amount is the In-Network Co-payment amount you will pay for primary care Covered Services rendered by Standard and Affinity Health Network (AHN) Providers
- **IN Specialty Care** - This amount is the In-Network Co-payment amount you will pay for specialty care Covered Services rendered by Standard and Affinity Health Network (AHN) Providers
- **IN Medical Ded** - This amount is the In-Network Medical Deductible you will pay before certain In-Network medical benefits are payable by Vantage
- **IN Combined OOP** – This amount is the maximum you will pay for In-Network EHB Covered Services for the Benefit Period and includes medical and Prescription Drug Cost Shares
- **OON Medical Ded** – This amount is the Out-of-Network Medical Deductible you will pay before certain Out-of-Network medical benefits are payable by Vantage

The Affinity Health Network (AHN) logo means your Cost Share will be lower when you receive certain Covered Services from AHN Providers. Services with reduced Cost Share are shown in the AHN column on your Member ID Card. Please see your Cost Share Schedule for a complete list of Cost Share. AHN Providers are listed on the Affinity Health Network pages in the first section of the Provider Directory and on our website, *www.VHP-StateGroup.com*.

All Members in this Plan have preventive and comprehensive dental coverage as indicated by the Dental Logo on the front of your Member ID Card.

Your Cost Share Schedule and this Certificate of Coverage details the Cost Share for these Covered Services.

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) 998-4371 or toll-free at (844) 833-7504 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.

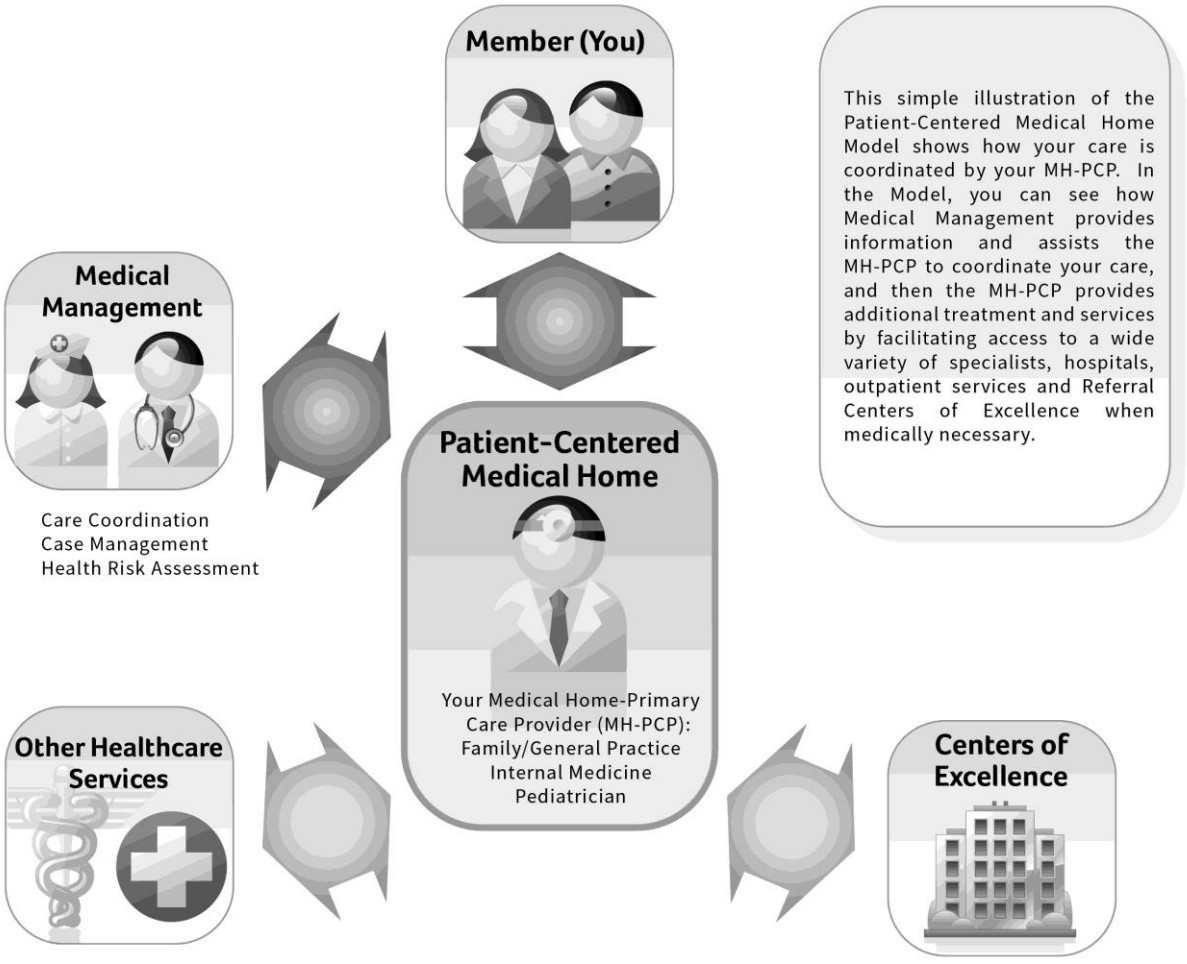
Medical Home Primary Care Provider (MH-PCP)
Each Vantage Member has an ongoing relationship with a personal Primary Care Provider trained to provide first contact and assist you in obtaining access to ongoing and comprehensive health care. The Medical Home Primary Care Provider (MH-PCP) will personally work with you to coordinate all of your health care. Your MH-PCP leads a team of clinical health care professionals who collectively take responsibility for your immediate and ongoing health care needs. PCMH health care professionals may also include 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.

Vantage requires the designation of a 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 In-Network MH-PCP who is available to accept you and/or your family Members as patients. For Children, you may designate an In-Network pediatrician as the MH-PCP. A woman may receive her primary care services through an In-Network obstetrician-gynecologist provider. Each family Member may have a different MH-PCP. To select a MH-PCP or to receive a list of In-Network Providers, visit us online at *https://portal.VantageHealthPlan.com/* or contact Vantage at (318) 998-4371 or toll-free at (844) 833-7504.

When your MH-PCP arranges for you to see a Specialty Care Provider or have a diagnostic test, the reports from that visit or test are automatically sent to your MH-PCP. If you see a Specialty Care Provider or have a diagnostic test that is not arranged by your MH-PCP, then you will need to ask that your reports be sent to your MH-PCP. Always make sure your MH-PCP is aware of all of your medical treatments and your other Health Care Providers. Referrals to In-Network Specialty Care Providers and OB/GYN's are not required 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 it is necessary.

PATIENT-CENTERED MEDICAL HOME MODEL



This simple illustration of the Patient-Centered Medical Home Model shows how your care is coordinated by your MH-PCP. In the Model, you can see how 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.

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
University of Mississippi Medical Center
Transplant Centers

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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 (Member ID Card). A sample Member ID Card is located on page 4 of this Certificate of Coverage.

Your Member ID Card should be kept with you at all times. Each time services are rendered, you should present your Member ID Card. For details about the Cost Share for which you are responsible, please refer to Section IV of this Certificate of Coverage, your Cost Share Schedule, the front of your Member ID Card or visit us online at ***https://portal.VantageHealthPlan.com/***. You may also contact the Member Services department at (318) 998-4371 or toll-free at (844) 833-7504.

Your Member 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 Member ID Cards or lose your Member ID Card, please visit us online at ***https://portal.VantageHealthPlan.com/*** or call the Member Services department. We will be happy to order you another set.

Network Design

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

In-Network - The In-Network benefits described in this Certificate of Coverage relate to Covered Services performed by Participating Providers (also referred to as In-Network Providers) who have current and valid agreements with Vantage. Members seeing Participating Providers pay the In-Network Medical Deductible, Co-payments, and Co-insurance as shown in the In-Network column in Section IV of this Certificate of Coverage, the Cost Share Schedule and/or the Member ID Card. In-Network Providers cannot Balance-Bill the Member.

AHN Providers are In-Network Providers with lower Cost Share for certain specified Eligible Charges and Prescription Drugs. This means your Cost Share will be lower when you receive those Covered Services from AHN Providers. Services with reduced Cost Share are shown on your Member ID Card and/or your Cost Share Schedule. AHN Providers are listed on the Affinity Health Network pages in the first section of the Provider Directory and on our website, *www.VHP-StateGroup.com*.

Out-of-Network – The Out-of-Network benefits described in this Certificate of Coverage relate to Covered Services performed by Out-of-Network Provider(s) who do not have a current and valid contract with Vantage at the time services are rendered.

Tier II - Vantage may contract with a nationwide Provider network available to Members living outside of the Vantage Service Area. These Participating Providers are considered Tier II Providers and cannot Balance-Bill the Member. The Pre-Authorization requirements for In-Network Covered Services as shown in Section IV of this Certificate of Coverage also apply to Tier II Providers.

Members living in the Vantage Service Area do not have access to the Tier II Network. If Members living within the Vantage Service Area receive services from Tier II Providers, they will be responsible for the Out-of-Network Cost Share unless the services rendered meet No Surprises Act (NSA) criteria. Always check a Provider's network status prior to receiving services.

Medical Management

Vantage assists the 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 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 PCP. Remember, the PCP is your personal Primary Care Provider.

A. **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 are subject to Plan requirements, benefit limits and Member eligibility at the time services are rendered.

Pre-Authorization requirements for Covered Services rendered by In-Network Providers are shown in Section IV of this Certificate of Coverage. NOTE: This list of services requiring Pre-Authorization is subject to change. You may call Member Services at (318) 998-4371 or toll-free at (844) 833-7504 for a current list of services that require Pre-Authorization. Most Out-of-Network Covered Services require Pre-Authorization except Emergency Medical Services.

Referrals to In-Network Specialty Care Providers and OB/GYN's are not required in this Plan.

B. **Vantage Medical Utilization Review Program**

Vantage has 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 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. In the vast majority of cases, a nurse reviewer can review and approve a request. 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 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 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.

Vantage does not compensate Medical Management nurses, Medical Directors, UM Committee members, and/or any other professionals who are involved in Utilization Review decisions for denials, does not offer incentives to encourage denials, and does not encourage decisions that result in underutilization. Vantage ensures independence and impartiality in making referral decisions and attests that involvement will not influence compensation, hiring, termination, promotion or any other similar matters for the Medical Management nurses, Medical Directors, UM Committee members, and/or any other professionals who are involved in Utilization Review decisions in the Utilization Review process based upon the likelihood or perceived likelihood that the Medical Management nurses, Medical Directors, UM Committee members, and/or any other professionals who are involved in Utilization Review decisions will support or tend to support the denial of benefits.

Is the Vantage Decision Final?
If you or your Physician disagrees with a Vantage denial, you may request an Appeal. Member Appeal processes are outlined in this Certificate of Coverage in Section XI.

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 Member 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.

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.

C. **Evaluation of New Technology**

Vantage has developed a medical policy for the purpose of providing guidelines for determining coverage criteria for specific recently developed and/or practiced medical and behavioral health care technologies, including procedures, equipment, pharmaceuticals, devices, and services. In order to be eligible for coverage, all services must be Medically Necessary. To the extent there are any conflicts between Vantage's medical policy guidelines and this Plan's language, the Plan's language prevails.

Issues are selected for medical policy development through referrals from Vantage staff, the Provider community, and Members. The technology assessment process is applied to both the development of new

medical policies and updates to existing medical policies. In order to determine whether a medical technology may be considered Medically Necessary, literature searches are conducted and the published scientific evidence related to each technology is reviewed.

Vantage medical policies are submitted for review to Vantage Medical Directors. Upon review, the Medical Directors will engage external practicing Physicians including Specialty Care Providers in the Vantage Service Area based on the areas of technology being evaluated and/or the specific medical discipline. Additional external resources may be utilized according to the complexity of the technology being evaluated. Opinions from these external sources will be compiled along with scientific evidence and the Medical Director summaries for the final approval process.

All policy drafts, including analyses of the scientific evidence and summaries of the external expert opinion, are presented to the Vantage Utilization Management Committee for final approval and implementation.

D. **How to Obtain Emergency Care and After Office Hours Care**

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 PCP will work with you to assure that you receive the medical care you need in an appropriate, cost-effective manner.

Call your PCP immediately when you require medical attention, even if you are traveling outside the Vantage Service Area. Your 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.

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.

E. **How to Obtain Coverage outside of the Vantage Service Area**

Our Plan does offer Out-of-Network coverage for certain Covered Services.

Members traveling outside of the state of Louisiana must contact the Vantage Medical Management department at (318) 998-4371 or toll-free at (844) 833-7504 prior to receiving non-Emergency Covered Services from Out-of-Network Providers. Most non-Emergency Covered Services rendered by Out-of-Network Providers require Pre-Authorization. Out-of-country services (excluding Emergency Medical Services) are not covered.

Members living outside of the state of Louisiana also have access to the Tier II Provider network for certain Covered Services. However, should these Members receive non-Emergency Covered Services from an Out-of-Network Provider, the Member must contact the Vantage Medical Management department at (318) 998-4371 or toll-free at (844) 833-7504 prior to receiving such services. Most non-Emergency Covered Services rendered by Out-of-Network Providers require Pre-Authorization.

F. **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 fairness, respect and recognition of 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 options for your conditions, regardless of cost or benefit coverage.
- ► A right to voice Grievances or file Appeals about Vantage, coverage decisions, its Health Care Providers, or the care provided.
- ► A right to make recommendations regarding Vantage's Member rights and responsibilities policy.
- ► A right to receive timely access to your Eligible Charges and Prescription Drugs.
- ► A right to privacy and the protection of your personal health information, in accordance with state and federal law.
- ► 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.

G. **Out-of-Network Coverage**

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) 998-4371 or toll-free at (844) 833-7504 to find out what the estimated 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 any Deductible or to the Out-of-Pocket Maximums.

However, Balance-Billing by Out-of-Network Providers is prohibited in certain situations. This includes all Out-of-Network Emergency Medical Services as well as certain ancillary services provided by Out-of-Network Providers in a non-Emergency setting at an In-Network facility. In these situations, your Cost Share must be: a) calculated using the In-Network benefit, and b) based on the lesser of billed charges or the Qualifying Payment Amount (QPA), which is generally the Plan's median contracted rate. You cannot be Balance-Billed for these services. The Cost Share for these Out-of-Network Covered Services will be used to meet your In-Network Medical Deductible and In-Network Out-of-Pocket Maximum.

IMPORTANT RULES TO HELP YOU USE THIS PLAN:

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

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

ALWAYS remember, your Cost Share for certain Covered Services provided by the Affinity Health Network may be lower. You may check the website or call Member Services for the most updated list of Affinity Health Network 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*. Such Pre-Authorization requirements for In-Network Covered Services also apply to Tier II Providers.

NOTE: This list of services requiring Pre-Authorization is subject to change. You may call Member Services at (318) 998-4371 or toll-free at (844) 833-7504 for a current list of services that require Pre-Authorization.

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.

Pre-Authorization is required for all non-emergent maternity admissions.

The Vantage Member Services department is available to assist you in using this Plan. Call (318) 998-4371 or toll-free at (844) 833-7504, Monday-Friday, 8:00 a.m. - 6:00 p.m. For language assistance services, please contact Vantage's Member Services department. For any Member who is deaf or hard of hearing, please call TTY 711. Vantage offers some language translation, sign language and teletypewriter (TTY) services to Members. The Language Translation Addendum is available upon request and is located online at: *https://www.VantageHealthPlan.com/documents/Marketplace/LanguageTranslationAddendum.pdf*.

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.

Adverse Determination means any of the following:

(a) A determination by Vantage that, based upon the information provided, a request for a benefit under the health insurance issuer's health benefit plan upon application of any utilization review technique does not meet Vantage's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit.
(b) The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by Vantage of a Member's eligibility to participate in the health insurance issuer's health benefit plan.
(c) Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a benefit under a health benefit plan.
(d) A Rescission of coverage determination.

Affinity Health Network (AHN) means In-Network Providers and pharmacies with lower Cost Share than the Plan's Standard Network Providers for certain specified Eligible Charges and Prescription Drugs. All AHN Co-payments are shown on the Cost Share Schedule and certain AHN Co-payments are shown on the Member ID Card.

Annual Enrollment is a period of time, designated by the Group, during which an Employee/Retiree may enroll for Health Insurance Coverages under this Group Health Plan or any other Plan.

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.

Authorized Representative means any of the following:

(a) A person to whom a Member has given express written consent to represent the Member. It may also include the Member's treating Health Care Provider if the Member appoints the Health Care Provider as his Authorized Representative and the Health Care Provider waives in writing any right to payment from the Member other than any applicable Cost Share amount. In the event that the service is determined not to be Medically Necessary, and the Member or his Authorized Representatives, except for the Member's treating Health Care Provider, thereafter requests the services, nothing shall prohibit the Health Care Provider from charging usual and customary charges for all non-Medically Necessary services provided.
(b) A person authorized by law to provide substituted consent for a Member.
(c) An immediate family member of the Member or the Member's treating Health Care Provider when the Member is unable to provide consent.
(d) In the case of an urgent care request, a Health Care Provider with knowledge of the Member's medical condition.

Balance-Billing or *Balance-Billed* means Out-of-Network providers may bill you for more than the Plan's allowed Cost Share amount. However, in accordance with the No Surprises Act (NSA), certain Out-of-Network providers are prohibited from Balance-Billing in certain situations. See the *No Surprises Act* definition below. In-Network providers cannot Balance-Bill or otherwise charge you more than the Cost Share amount your Plan says you must pay for Covered Services.

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 (Affinity Health Network, In-Network, and Out-of-Network) has a different Cost Share for the Member as indicated in Section IV of this Certificate of Coverage and/or in the Cost Share Schedule.

Benefit Period is a calendar year, January 1 through December 31. For the new Plan Participants, the Benefit Period begins on the Effective Date and ends on December 31 of the same year. The Benefit Period resets on any break in coverage or if the Employee enrolls in another Vantage plan.

Child or Children means:

(a) A Child of the Employee/Retiree;
(b) A Child of the Employee's/Retiree's Spouse (a "stepchild");
(c) A Child placed for adoption with the Employee/Retiree;
(d) A Child under the court-ordered legal guardianship or in the court-ordered custody of the Employee/Retiree;
(e) A grandchild or dependent of a dependent of the Employee/Retiree whose parent is covered under the Plan as a Dependent, or a child for whom the Employee/Retiree has current provisional custody, which grandchild/child has not been adopted by the Employee/Retiree and for whom the Employee/Retiree has not obtained court-order legal guardianship/tutorship or court-ordered custody, provided the grandchild/child was enrolled as a Plan Participant and met the eligibility requirements of a "Child" as of December 31, 2015.

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.

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 Cost Share Schedule and/or in Section IV*: Schedule of Covered Services & Benefits* of this Certificate of Coverage. Co-insurance applies after and does not apply toward the Deductible(s).

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, apply before the In-Network Medical Deductible, and do not apply toward any Deductible.

Code The Internal Revenue Code of 1986, as amended, and the regulations promulgated thereunder.

Company Vantage Health Plan, Inc. or "Vantage."

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.

Cost Share means the Deductible, Co-payment, and Co-insurance amounts or percentages that are the Member's financial responsibility and are based on the type of Covered Service and the Provider network. Member medical Cost Share amounts are applied in the following order: 1) Out-of-Network Medical Deductible and Co-insurance, 2) Supplementary Benefit Co-insurance, 3) In-Network Co-payments, 4) In-Network Medical Deductible, and 5) In-Network Co-insurance.

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

Covered Person see *Member or Plan Participant* definition.

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. Covered Services include services and supplies in accordance with PPACA and state laws, as applicable.

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.

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

(A) Spouse – the date of marriage

(B) Child or Children

1. Natural Children – the date of birth
2. Children placed for adoption with the Employee/Retiree:
    a. Agency adoption – the date the adoption contract was executed between the Employee/Retiree and the adoption agency.
    b. Private adoption – the date the Act of Voluntary Surrender is executed in favor of the Employee/Retiree. The Plan Administrator 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.
3. Child for whom the Employee/Retiree has court-ordered custody or court-ordered legal guardianship – the date of the court order granting legal custody or guardianship.
4. Stepchild – the date of the marriage of the Employee/Retiree to his/her Spouse.

Deductible means the amounts shown on the Cost Share Schedule that the Member or family must pay each Benefit Period before certain medical benefits are payable under the Plan. A single family Member has met his/her Deductible by reaching the applicable individual Deductible amount. Other family Members' payments for Eligible Charges combine to meet the remainder of the applicable family Deductible amount. Co-insurance and Co-payments do not apply toward Deductibles. Charges above the Vantage Allowable for services provided by Out-of-Network Providers do not apply toward the Deductibles. There are two (2) Deductibles: In-Network Medical and Out-of-Network Medical.

a) The *In-Network Medical Deductible* applies to Eligible Charges to be paid by each Member or family for In-Network benefits during the Benefit Period and are based on the Benefit Level of the rendering Provider. The In-Network Medical Deductible applies to the In-Network Out-of-Pocket Maximum, excluding any portion of the In-Network Medical Deductible which was met by services listed as "Exclusions and limitations for In-Network Out-of-Pocket Maximum" in Section IV.

b) The *Out-of-Network Medical Deductible* applies to Eligible Charges to be paid by each Member or family for Out-of-Network benefits during the Benefit Period. All Out-of-Network Eligible Charges are subject to the Out-of-Network Medical Deductible except Emergency Medical Services, services covered under the No Surprises Act (NSA), wellness and preventive care, dental services, and glasses/contact lenses. The Out-of-Network Medical Deductible does not apply to the In-Network Out-of-Pocket Maximum. There is no Out-of-Network Out-of-Pocket Maximum.

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

(A) the covered Employee's/Retiree's Spouse;

(B) a Child from Date Acquired until end of month of attainment of age twenty-six (26), except for the following:

1. A grandchild or dependent of a dependent of the Employee/Retiree whose parent is covered under the Plan as a Dependent and for whom the Employee/Retiree has not obtained court-ordered legal guardianship/tutorship or court-ordered custody and has not adopted, which grandchild or dependent of a dependent was covered under the Plan and met the definition of a "Child" as of December 31, 2015, from Date Acquired until end of month the parent Dependent Child is no longer enrolled on or eligible to participate in the Plan, the end of the month the grandchild or dependent of a dependent turns twenty-six (26), or the grandchild or dependent of a dependent no longer meets the eligibility requirements under this Plan, whichever is earlier;
2. A Child for whom the Employee/Retiree has current provisional custody and for whom the Employee/Retiree has not obtained court-ordered legal guardianship/tutorship or court-ordered custody and has not adopted, which child was covered under the Plan and met the definition of a "Child" as of December 31, 2016, from Date Acquired until the end of the month of the 2017 anniversary date of the existing provisional custody document, the end of the month the child reaches the age of eighteen (18), or December 31, 2017, whichever is earlier;
3. A Child for whom the Employee/Retiree has court-ordered custody or court-ordered legal guardianship/tutorship but who has not been adopted by the Employee/Retiree, from Date Acquired until the end of the month the custody/guardianship/tutorship order expires or the end of the month the Child reaches the age of eighteen (18), whichever is earlier;
4. A stepchild of the Employee/Retiree, which stepchild has not been adopted by the Employee/Retiree and for whom the Employee/Retiree does not have court-ordered custody or court-ordered legal guardianship/tutorship, from Date Acquired until the end of the month that the Employee/Retiree is no longer married to the stepchild's parent, the end of the month of the death of the parent of the stepchild, or the end of the month the stepchild reaches the age of twenty six (26), whichever is earlier.

(C) A Child of any age who meets the criteria set forth in the Eligibility Section of this Certificate.

DeSiard Pharmacy Network (DPN) is Vantage Health Plan's preferred network of independent pharmacies with lower Cost Share than the Plan's other In-Network pharmacies for certain Prescription Drugs. Members have no Cost Share for diabetic supplies, diabetic meters, and Tier I Prescription Drugs filled by DPN Pharmacies. See additional information in Section IV of this Certificate of Coverage.

Developmental Condition or Developmental Disorder refers to an impairment in normal development of language, 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/Retiree)– the following written proof of relationship to the Employee/Retiree has been presented for inspection and copying to OGB, or to a representative of the Employee/Retiree's Participant Employer designated by OGB:

(A) The covered Employee/Retiree's legal Spouse - Certified copy of certificate of marriage indicating date and place of marriage;

(B) Child:

1. Natural or legally adopted Child of Employee/Retiree - Certified copy of birth certificate listing Member as parent or certified copy of legal acknowledgment of paternity signed by Employee/Retiree or certified copy of adoption decree naming Employee/Retiree as adoptive parent;
2. Stepchild - Certified copy of certificate of marriage to spouse and birth certificate or adoption decree listing Spouse as natural or adoptive parent;
3. 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;
4. Child placed with your family for adoption by agency adoption or irrevocable Act of Voluntary Surrender for private adoption - Certified copy of adoption placement order showing date of placement or copy of signed and dated irrevocable Act of Voluntary Surrender;

5. Child for whom you have been granted court-ordered legal guardianship or court-ordered custody - Certified copy of the signed court order granting legal guardianship or custody;

(C) 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 2e 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;

(D) Such other written proof of relationship to the Employee/Retiree deemed sufficient by OGB.

Drug(s) or Medication(s) refers to all Prescription Drugs and Non-Prescription Drugs, including narcotics.

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

Effective Date is the date when the Plan Participant's coverage begins under this Benefit Plan as determined by the Schedule of Eligibility. Benefits will begin at 12:01 A.M. on this date.

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.

Eligible Person means a person entitled to apply to be a Plan Participant as specified in Section VI of this Certificate.

Emergency Medical Condition or Emergency is a medical condition of recent onset and severity, including severe pain, that 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: (1) Placing the health of the individual, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy; (2) Serious impairment to bodily function; or (3) 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 as defined by the respective Participant Employer and in accordance with state law, and any Full-Time Equivalent.

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.

Essential Health Benefits (EHB) means a set of health care service categories that must be covered by certain plans. The Affordable Care Act ensures health plans offer a comprehensive package of items and services, and must include items and services within at least the following ten (10) categories: ambulatory patient services; Emergency Medical Services; hospitalization; maternity and Newborn care; mental health and substance use disorder services, including behavioral health treatment; Prescription Drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

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; 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.

Final Adverse Determination means an Adverse Determination, including medical judgment, involving a Covered Service that has been upheld by Vantage, or its designee utilization review organization, at the completion of Vantage's internal claims and Appeals process procedures provided pursuant to La. R.S. 22:2401.

Full Time Equivalent (FTE) means a full-time equivalent Employee who is employed on average 30 or more hours per week, as defined under Code Section 4980H and determined pursuant to the regulations issued thereunder.

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. Grievances may also be submitted to the Louisiana Department of Insurance for review. See Section XI of this Certificate of Coverage for information regarding grievances.

Group Health Plan means an employee welfare benefit plan (as defined in 29 U.S.C. Chapter 18 (ERISA) and 42 CFR 3.20) 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.

Habilitative Services and Devices means ongoing, Medically Necessary outpatient therapies provided to Members with Developmental Conditions and similar conditions who need habilitation therapies to achieve functions and skills. Habilitative services and devices help a person keep, learn, or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Care Provider(s) or 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), optometrist (OD), anesthetist, including certified registered nurse anesthetist (CRNA), or a psychologist licensed by the proper regulatory agency of the state. Health Care Provider(s) 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, training, or schooling.

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 Cost Share means the Deductible(s), Co-payments and Co-insurance referred to in the "In-Network" column in Section IV of this Certificate of Coverage. Certain Covered Services are available from Affinity Health Network and DPN Providers at a lower Cost Share.

In-Network Out-of-Pocket Maximum means the maximum out-of-pocket amount related to services obtained from In-Network Providers. See *Initial In-Network Medical Out-of-Pocket Maximum* and *PPACA In-Network Medical Out-of-Pocket Maximum* definition.

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

Independent Review Organization (IRO) means an entity that conducts independent external reviews of Adverse Determinations and Final Adverse Determinations.

Initial In-Network Medical Out-of-Pocket Maximum or In-Network Medical Out-of-Pocket Maximum means the specified Cost Share amounts listed in the Cost Share Schedule for which a Member or family is responsible for certain In-Network Essential Health Benefits (EHB) Eligible Charges and the Cost Share paid for those Out-of-Network services covered under the No Surprises Act (NSA). In-Network Medical Out-of-Pocket Maximum exclusions and limitations are described in Section IV. The Initial In-Network family Medical Out-of-Pocket Maximum can be met by two or more family Members.

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 Period for the individual.

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

Medical Deductible Medical Deductible applies to Eligible Charges to be paid by each Member or family during the Benefit Period. See *Deductible* definition.

Medical Home Primary Care Provider (MH-PCP) or Primary Care Provider (PCP) means a Participating family practice, general practice, general pediatrician or general internal medicine Physician, or a nurse practitioner or physician assistant practicing in those fields, who is selected by a Vantage Member, and provides the Member with entry into the health care system. A Primary Care Provider: (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.

Member(s) or Covered Person(s) or Plan Participant means an Active Employee or Retiree, their eligible Dependent(s), or any other individual eligible for coverage under the Eligibility Section of this Certificate or state or federal law for whom the necessary application forms have been completed, for whom the required contribution has been made, and for whom the Plan Administrator has accepted Eligibility and enrolled into the Plan. The term Covered Person, defined here, is used interchangeably with the term Plan Participant.

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.

No Surprises Act (NSA) is effective January 1, 2022, and prohibits the practice of Balance-Billing by Out-of-Network providers in certain situations, including all Out-of-Network Emergency Medical Services as well as certain ancillary services provided by Out-of-Network providers in a non-Emergency setting at an In-Network facility. The NSA also requires the Plan to use a Qualified Payment Amount (QPA) to calculate the Member Cost Share in those situations, which must be calculated as if those services were provided by an In-Network provider.

Non-Essential Health Benefits (Non-EHB) means Covered Services other than Essential Health Benefits.

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 support 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 (OON) means services obtained from Out-of-Network Providers.

Out-of-Network Benefit Maximum means the maximum amount Vantage will pay for Out-of-Network Eligible Charges. The Out-of-Network Benefit Maximum is $5,000 for an individual policy and $15,000 for a family policy. Once the Plan has paid the applicable amount of the Vantage Allowable for Out-of-Network benefits, the Member will pay 100% of all Out-of-Network benefits for the remainder of the Benefit Period.

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-Network Providers may Balance-Bill a Member.

Out-of-Pocket Maximum (OOP) see *Initial In-Network Medical Out-of-Pocket Maximum or PPACA In-Network Out-of-Pocket Maximum* definitions.

Participant or Plan Participant see *Member* or *Covered Persons* definitions.

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 or In-Network Provider means those Health Care Providers who have current and valid agreements with Vantage to provide Covered Services to Members. Participating Providers include Vantage's Standard Network Providers, DeSiard Pharmacy Network pharmacies, Affinity Health Network Providers and Tier II Providers.

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 and Prescription Drug Plan established by the Office of Group Benefits for Plan Participants as offered in this Certificate of Coverage.

Plan Administrator refers to Office of Group Benefits, who administers these Benefits on behalf of the State of Louisiana, for eligible Employees, Retirees and Dependents for Participant Employers.

Plan Drug Formulary or 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.

PPACA In-Network Out-of-Pocket Maximum (Patient Protection and Affordable Care Act) means the amounts for which a Member or family is responsible for In-Network EHB Covered Services pursuant to PPACA regulations. PPACA limits the Member's In-Network Cost Share for Essential Health Benefits (EHB) to the annual out-of-pocket maximum as determined by the Internal Revenue Service. Out-of-Network and Non-EHB Eligible Charges as well as certain other Member payments are excluded from the PPACA In-Network Out-of-Pocket Maximum as listed in Section IV. The family PPACA In-Network Out-of-Pocket Maximum can be met by two or more family Members.

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.

Premium or Premium Payment means the amount of money due to Vantage each month for medical and prescription drug coverage.

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.

Prosthetic Services means the science and Medically Necessary practice of evaluating, measuring, designing, fabricating, assembling, fitting, aligning, adjusting or servicing of a Prosthesis through the replacement of external parts of a human body lost due to amputation or congenital deformities to restore function, cosmeses, or both.

Provider(s) – see *Health Care Provider(s)* definition.

Qualifying Payment Amount (QPA) is the Plan's median contracted rate with In-Network providers, is applicable to services provided to Out-of-Network providers in certain situations, and is calculated in accordance with the No Surprises Act. The QPA is the basis on which a Member's Cost Share is determined in these situations.

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.

Rescission means cancellation or discontinuance of coverage under Vantage that has a retroactive effect. The term shall not include a cancellation or discontinuance of coverage under a health benefit plan if either:

(a) The cancellation or discontinuance of coverage has only a prospective effect.
(b) The cancellation or discontinuance of coverage is effective retroactively to the extent that it is attributable to a failure to timely pay required Premiums or contributions towards the cost of coverage.

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

(A) Immediately received a retirement plan distribution from an approved state or governmental agency defined benefit plan;
(B) Was not eligible for participation in such plan or legally opted not to participate in such plan; and either:
    1. Began employment prior to September 15, 1979, has ten (10) years of continuous state service, and has reached the age of sixty-five (65);
    2. Began employment after September 16, 1979, has ten (10) years of continuous state service, and has reached the age of seventy (70);
    3. Began employment after July 8, 1992, has ten (10) years of continuous state service, has a credit for a minimum of forty (40) quarters in the Social Security system at the time of employment, and has reached the age of sixty-five (65); or
    4. Maintained continuous coverage with the Plan as an eligible Dependent until he became eligible to receive a retirement benefit from an approved state governmental agency defined Benefit Plan as a former State Employee.
    (C) Immediately received a retirement plan distribution from a state-approved or state governmental agency approved defined contribution plan and has accumulated the total number of years of creditable service which would have entitled him to receive a retirement allowance from the defined benefit plan of the retirement system for which the Employee would have otherwise been eligible. The appropriate state governmental agency or retirement system responsible for administration of the defined contribution plan is responsible for certification of eligibility to the Office of Group Benefits.
(D) 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 A, B, or C above.

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

(A) 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
(B) 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
(C) Maintains clinical records of each patient; and
(D) Has appropriate methods and procedures to administer Drugs to patients; and
(E) Is not an institution, or part of an institution, that is:

1. A Hospital; or
2. Primarily for the care of mental Illness, Drug addiction, alcoholism, or tuberculosis; or
3. 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 the Employer contributions were terminated, in which case an Employee may enroll in this Plan.

Specialty Care Provider is a medical or surgical Physician, nurse practitioner, and physician assistant other than gynecologists and those providers defined as Primary Care Providers.

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, cognitive-communication and swallowing disorders in individuals of all ages from infants to the elderly.

Spouse means the Employee's Spouse pursuant to a marriage recognized under state law where the marriage was entered.

Stabilize means to provide treatment that assures that no material deterioration of the condition is likely to result from or occur during the transfer of the Member from a facility.

Standard Network In-Network Providers other than the DeSiard Pharmacy Networks, Affinity Health Network Providers or Tier II Providers.

Supplementary Benefits are additional benefits above and beyond the basic health benefits. There is no Out-of-Network coverage for these benefits.

Temporarily Medically Disabled Mother means a woman who has recently given birth and whose Physician has advised that normal travel would be hazardous to her health.

Tier II Provider or Tier II A nationwide Provider network available to Members living outside of the Vantage Service Area (state of Louisiana). Tier II Providers outside the Vantage Service Area cannot Balance-Bill out-of-state Members. Members living in the Vantage Service Area do not have access to the Tier II Provider network.

Urgent Care Center means a Physician's office, 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, other outpatient emergency department or other outpatient Hospital facility.

Utilization Management (UM) 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.

Vantage Allowable means the amount Vantage would pay to an In-Network Provider for the Covered Service as specified in the Provider contract or the amount set forth in the Vantage Allowable fee schedule, as determined by Vantage.

Vantage Service Area means the geographic area (the state of Louisiana) served by Vantage as approved by the Louisiana Department of Insurance 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 Health Plan and subject to the exclusions and limitations listed in Section V of this 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 Deductibles, Co-payments, and Co-insurance shown in the Cost Share Schedule and/or in this Section IV. Deductibles, Co-payments, and Co-insurance are a Member's responsibility and may be due at the time services are rendered.

NOTICE: YOUR SHARE OF THE PAYMENT FOR HEALTH CARE SERVICES MAY BE BASED ON THE AGREEMENT BETWEEN YOUR HEALTH PLAN AND YOUR PROVIDER. UNDER CERTAIN CIRCUMSTANCES, THIS AGREEMENT MAY ALLOW YOUR PROVIDER TO BILL YOU FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES.

Deductible(s)

The Deductible(s) that apply to this Plan are specified in the Cost Share Schedule. There are separate In-Network and Out-of-Network Medical Deductibles which must be met before most benefits are payable under the Plan. Eligible Charges which are subject/not subject to a Deductible are noted in the applicable benefits in this Section.

The Deductibles are the amounts shown on the Cost Share Schedule that the Member or family must pay each Benefit Period before certain medical benefits are payable under the Plan. A single family Member has met his/her Deductible(s) by reaching the individual Deductible amount. Other family Members' payments for Eligible Charges combine to meet the remainder of the applicable family Deductible amount. Co-insurance and Co-payments do not apply toward any Deductible. Charges above the Vantage Allowable for services provided by Out-of-Network Providers do not apply toward any Deductible.

There are two (2) Deductibles: In-Network Medical and Out-of-Network Medical.

a) The *In-Network Medical Deductible* applies to Eligible Charges to be paid by each Member or family for In-Network benefits during the Benefit Period and are based on the Benefit Level of the rendering Provider. The In-Network Medical Deductible applies to the In-Network Out-of-Pocket Maximums, excluding any portion of the In-Network Medical Deductible which was met by services listed in the exclusions and limitations below.

b) The *Out-of-Network Medical Deductible* applies to Eligible Charges to be paid by each Member or family for Out-of-Network benefits during the Benefit Period. All Out-of-Network Eligible Charges are subject to the Out-of-Network Medical Deductible except Emergency Medical Services, services covered under the No Surprises Act (NSA), wellness and preventive care, dental services, and glasses/contact lenses. The Out-of-Network Medical Deductible does not apply to the In-Network Out-of-Pocket Maximums. **There is no Out-of-Network Out-of-Pocket Maximum. The Out-of-Network Benefit Maximum for Out-of-Network Eligible Charges is $5,000 for an individual policy and $15,000 for a family policy. Once the Plan has paid the applicable amount of the Vantage Allowable for Out-of-Network benefits, the Member will pay 100% of all Out-of-Network benefits for the remainder of the Benefit Period.**

IN-NETWORK:

In-Network Medical Deductible

In-Network Eligible Charges which are subject/not subject to the In-Network Medical Deductible are noted in the applicable benefits in this Section. After a Member's payments for In-Network Eligible Charges which are subject to the In-Network Medical Deductible equal the In-Network Medical Deductible, the Member will pay the In-Network Eligible Charges at the Co-insurance percentages stated in the Cost Share Schedule.

Prescription Drug Deductible

There is no Deductible for Prescription Drug benefits.

In-Network Out-of-Pocket Maximums

The Out-of-Pocket Maximums described below will limit the amount a Member will pay out-of-pocket for In-Network Benefit Level Covered Services each Benefit Period subject to the exclusions and limitations listed below.

Co-payments or Co-insurance for In-Network Eligible Charges which are included in or excluded from one or both of the In-Network Out-of-Pocket Maximums below are noted in the applicable benefits in this Section. The In-Network Eligible Charges that are included in the In-Network Medical Deductible are included in **both** the Initial In-Network Medical Out-of-Pocket Maximum and the PPACA In-Network Out-of-Pocket Maximum.

► ***Initial In-Network Medical Out-of-Pocket Maximum***

Individual: The Initial In-Network Medical Out-of-Pocket Maximum for In-Network Benefit Level Eligible Charges is the amount specified in the Cost Share Schedule. After a Member's share of In-Network Benefit Level Eligible Charges to be paid during a Benefit Period equals the applicable individual Initial In-Network Medical Out-of-Pocket Maximum specified in the Cost Share Schedule, the Plan will pay In-Network Benefit Level Eligible Charges for that Member at 100% of the Vantage Allowable for the remainder of the Benefit Period subject to the exclusions and limitations listed below.

Family: The Out-of-Pocket Maximum for In-Network Benefit Level Eligible Charges is the amount specified in the Cost Share Schedule. The family Initial In-Network Medical Out-of-Pocket Maximum can be met by two or more family Members. A single family Member has met his/her Initial In-Network Medical Out-of-Pocket Maximum by reaching the Individual Initial In-Network Medical Out-of-Pocket amount. Other family Members' payments for Eligible Charges combine to meet the remainder of the family Initial In-Network Medical Out-of-Pocket Maximum amount. After a Member's and his/her Dependents' shares of In-Network Benefit Level Eligible Charges to be paid during a Benefit Period equals the applicable family Initial In-Network Medical Out-of-Pocket Maximum specified in the Cost Share Schedule, the Plan will pay In-Network Benefit Level Eligible Charges for that 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.

Exclusions and limitations for Initial In-Network Medical Out-of-Pocket Maximum

Charges incurred by a Member for the following will NOT be applied to the Initial In-Network Medical Out-of-Pocket Maximum:

i. Office visit Co-payments
ii. Durable Medical Equipment Co-insurance
iii. After-Hours/Walk-In Clinics and Urgent Care Centers Co-payments
iv. Certain Other Covered Services (as noted in the applicable benefits in this Section)
v. Supplementary Benefits Co-insurance and Co-payment
vi. Vision Covered Services Co-payments and Co-insurance
vii. Comprehensive Dental Services Co-insurance
viii. Orthodontia for Children Co-insurance
ix. Outpatient Mental Health and Alcohol & Chemical Dependency Services Co-payments
x. Approved Transplant Services Co-payments
xi. Prescription Drug Co-payments
xii. Approved clinical trials Cost Share
xiii. Out-of-Network Medical Deductible and Co-insurance

xiv. Prescription Drugs not included in the Plan Drug Formulary, except when approved through the Drug exception process
xv. Charges in excess of the maximum benefit available, including the difference between the cost of a brand name Prescription Drug and the cost of its Generic Drug equivalent
xvi. Prescription Drugs received from Out-of-Network pharmacies (unless approved as an out-of-area Emergency)
xvii. Charges above Vantage's Participating pharmacy reimbursement rate for Prescription Drugs received from an Out-of-Network Provider in an approved out-of-area Emergency
xviii. Specialty Drugs not provided by an In-Network Participating specialty pharmacy
xix. Services performed by Out-of-Network Providers except for services covered under the No Surprises Act (NSA) that do not fall under categories (i) through (xii) above
xx. Charges that are not Covered Services
xxi. Charges above the Vantage Allowable for non-NSA Covered Services performed by Out-of-Network Providers
xxii. Monthly Premium Payments

► ***PPACA In-Network Out-of-Pocket Maximum***

PPACA limits the Member's Cost Share for In-Network Essential Health Benefits (EHB) to the annual out-of-pocket maximum as determined by the Internal Revenue Service. Prescription Drug Covered Services are EHB Covered Services. The PPACA In-Network Out-of-Pocket Maximum is **$8,700** for an individual policy and **$17,400** for a family policy.

Individual: The PPACA In-Network Out-of-Pocket Maximum is a Member's share of In-Network EHB Covered Services (including items i. through x. above in the Initial In-Network Medical Out-of-Pocket Maximum exclusions list) and is subject to the exclusions and limitations noted below. After a Member's share of such In-Network Covered Services to be paid during a Benefit Period equals the PPACA In-Network Out-of-Pocket Maximum, the Plan will pay those In-Network Covered Services for the Member at 100% of the Vantage Allowable for the remainder of the Benefit Period.

Family: The PPACA In-Network Out-of-Pocket Maximum is a Member's and his or her Dependents' shares of In-Network EHB Covered Services (including items i. through x. above in the Initial In-Network Medical Out-of-Pocket Maximum exclusions list) and is subject to the exclusions and limitations noted below. The family PPACA In-Network Out-of-Pocket Maximum can be met by two or more family Members. A single family Member has met his/her PPACA In-Network Out-of-Pocket Maximum by reaching the individual PPACA In-Network Out-of-Pocket Maximum amount. Other family Members' payments for Covered Services combine to meet the remainder of the family PPACA In-Network Out-of-Pocket Maximum amount. After a Member's and his/her Dependents' shares of such In-Network Covered Services to be paid during a Benefit Period equals the applicable family PPACA In-Network Out-of-Pocket Maximum amount, the Plan will pay those In-Network Covered Services for that Member and his or her Dependents at 100% of the Vantage Allowable for the remainder of the Benefit Period.

Exclusions and limitations for PPACA In-Network Out-of-Pocket Maximum

Out-of-Network and Non-EHB Eligible Charges as well as certain other Member payments (shown below) are excluded from the PPACA In-Network Out-of-Pocket Maximum. Charges incurred by a Member or any Dependent for the following will NOT be applied to the PPACA In-Network Out-of-Pocket Maximum:

i. Any portion of the Deductible which was met by any of the exclusions listed below
ii. Adult Vision Co-payments and Co-insurance
iii. Comprehensive Dental Services for adults Co-insurance
iv. Out-of-Network Medical Deductible and Co-insurance
v. Prescription Drugs not included in the Plan Drug Formulary, except when approved through the Drug exception process
vi. Charges in excess of the maximum benefit available, including the difference between the cost of a brand name Prescription Drug and the cost of its Generic Drug equivalent

vii. Prescription Drugs received from Out-of-Network pharmacies (unless approved as an out-of-area Emergency)
viii. Charges above the Vantage Participating pharmacy reimbursement rate for Prescription Drugs received from an Out-of-Network Provider in an approved out-of-area Emergency
ix. Specialty Drugs not provided by the Plan's contracted specialty pharmacy
x. Services performed by Out-of-Network Providers (except for services covered under the No Surprises Act (NSA)
xi. Charges that are not Covered Services
xii. Charges above the Vantage Allowable for non-NSA Covered Services performed by Out-of-Network Providers
xiii. Monthly Premium Payments

OUT-OF-NETWORK:

Out-of-Network Medical Deductible

The Out-of-Network Medical Deductible is the amount that the Member must pay each Benefit Period before all Out-of-Network medical benefits (excluding services covered under the No Surprises Act (NSA), wellness and preventive care, dental services, and glasses/contact lenses for adults) are payable under the Plan. Charges above the Vantage Allowable incurred by a Member for services provided by Out-of-Network Providers do not apply toward the Out-of-Network Medical Deductible.

Individual: After a Member's Out-of-Network Benefit Level Eligible Charges to be paid during a Benefit Period equals the Out-of-Network Medical Deductible, the Member will pay Out-of-Network Co-insurance as shown in the Cost Share Schedule. Out-of-Network Providers may Balance Bill the Member.

Family: The family Out-of-Network Medical Deductible can be met by two or more family Members. A single family Member has met his/her Out-of-Network Medical Deductible by reaching the Individual Out-of-Network Medical Deductible amount. Other family Members' payments for Covered Services combine to meet the remainder of the family Out-of-Network Medical Deductible amount. After a family's Out-of-Network Benefit Level Eligible Charges to be paid during a Benefit Period equals the Out-of-Network Medical Deductible, the family will pay Out-of-Network Co-insurance as shown in this section. Out-of-Network Providers may Balance Bill the Member.

Out-of-Network Out-of-Pocket Maximum

There is no Out-of-Pocket Maximum for Out-of-Network Covered Services.

Out-of-Network Benefit Maximum

The Out-of-Network Benefit Maximum for Out-of-Network Eligible Charges is $5,000 for an individual policy and $15,000 for a family policy. Once the Plan has paid the applicable amount of the Vantage Allowable for Out-of-Network benefits, the Member will pay 100% of all Out-of-Network benefits for the remainder of the Benefit Period.

AHN Providers are In-Network Providers with lower Cost Share for certain specified Eligible Charges and Prescription Drugs. This means your Co-payments will be lower when you receive those Covered Services from AHN Providers. Services with reduced Co-payments are shown on your Member ID Card and/or your Cost Share Schedule. AHN Providers are listed on the Affinity Health Network pages in the first section of the Provider Directory and on our website, *www.VHP-StateGroup.com*.

The In-Network benefits that appear on the following pages must be arranged by your PCP and indicate whether In-Network Pre-Authorization is required.

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

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 to any Deductible or to any Out-of-Pocket Maximum.

Balance-Billing by Out-of-Network Providers is prohibited in certain situations, including all Out-of-Network Emergency Medical Services as well as certain ancillary services provided by Out-of-Network Providers in a non-Emergency setting at an In-Network facility. In these situations, your Cost Share must be: a) calculated using the In-Network benefit, and b) based on the lesser of billed charges or the Qualifying Payment Amount (QPA), which is generally the Plan's median contracted rate. You cannot be Balance-Billed for these services. The Cost Share for these Out-of-Network Covered Services will be used to meet your In-Network Medical Deductible and In-Network Out-of-Pocket Maximum.

All Out-of-Network Eligible Charges are subject to the Out-of-Network Medical Deductible except services covered under the No Surprises Act (NSA), wellness and preventive care, dental services, and glasses/contact lenses.

Most non-Emergency Covered Services rendered by Out-of-Network Providers require Pre-Authorization.

Specialty Drugs must be provided by an In-Network Participating specialty pharmacy. When Specialty Drugs are not provided by an In-Network Participating 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 In-Network Participating specialty pharmacy less the Member's Cost Share.

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

- Covered Services are subject to the Deductibles, Co-payments, Co-insurance, and maximums shown in this Certificate of Coverage and/or the Cost Share Schedule.
- Co-insurance and Co-payment amounts do not apply *toward* any Deductible.
- Member medical Cost Share amounts are applied in the following order: 1) Out-of-Network Medical Deductible and Co-insurance, 2) Supplementary Benefit Co-payments or Co-insurance, 3) In-Network Co-payments, 4) In-Network Medical Deductible, and 5) In-Network Co-insurance.
- The In-Network Medical Deductible *does* apply to both the Initial In-Network and the PPACA In-Network Out-of-Pocket Maximums.
- Certain In-Network Co-payments and Co-insurance amounts or percentages do not apply to the In-Network Out-of-Pocket Maximums and are noted in the applicable benefits in this section.
- There is no Out-of-Pocket Maximum for Out-of-Network Benefit Level or Non-EHB Covered Services.
- **There is an Out-of-Network Benefit Maximum. Once the Plan has paid the applicable amount of the Vantage Allowable for Out-of-Network benefits, the Member will pay 100% of all Out-of-Network benefits for the remainder of the Benefit Period.**

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	IN-NETWORK	OUT-OF-NETWORK*
Primary Care Provider (PCP) Office Visits: Family practice, general internal medicine, general pediatrician or general practice Physicians, and nurse practitioners or physician assistants practicing in those fields.	100% Coverage of Vantage Allowable less the Primary Care Provider office visit Co-payment. Out-of-Pocket Maximum: Initial: **Excluded** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
Gynecology Office Visits:	100% Coverage of Vantage Allowable less the Primary Care Provider office visit Co-payment. Out-of-Pocket Maximum: Initial: **Excluded** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
Specialty Care Provider Office Visits (including consultation and second opinion visits): Medical or surgical Physicians, nurse practitioners, and physician assistants other than gynecologists and those providers defined as Primary Care Providers.	100% Coverage of Vantage Allowable less the Specialty Care office visit Co-payment. Out-of-Pocket Maximum: Initial: **Excluded** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.

* If you receive treatment from an Out-of-Network Provider for non-NSA Covered Services, you may be Balance-Billed. See Out-of-Network Coverage section in Section II for more information. In-Network Providers cannot Balance Bill Members. Most non-Emergency Covered Services rendered by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

Physician Office Services (continued)

COVERED SERVICE	IN-NETWORK	OUT-OF-NETWORK*
Office Procedures and Diagnostic Services Lab and x-ray services performed in the Physician office.		
► Lab	100% Coverage of Vantage Allowable. Not subject to In-Network Medical Deductible.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
► Specified other lab **Requires Pre-Authorization.**	100% Coverage of Vantage Allowable. Not subject to In-Network Medical Deductible. Contact the Plan for details.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
► X-rays, other office procedures[1], and diagnostic services, excluding major diagnostic testing. **[1]May require Pre-Authorization.**	100% Coverage of Vantage Allowable. Not subject to In-Network Medical Deductible.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
► Major diagnostic testing (See list of services in the Outpatient Hospital Services category.) **Requires Pre-Authorization.**	100% Coverage of Vantage Allowable less the applicable major diagnostic Co-payment per test. Out-of-Pocket Maximum: Initial: **Included** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.

* If you receive treatment from an Out-of-Network Provider for non-NSA Covered Services, you may be Balance-Billed. See Out-of-Network Coverage section in Section II for more information. In-Network Providers cannot Balance Bill Members. Most non-Emergency Covered Services rendered by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

Maternity-Related Services

COVERED SERVICE	IN-NETWORK	OUT-OF-NETWORK*
Office Visits:	100% Coverage of Vantage Allowable less applicable Primary Care Provider office visit Co-payment on initial visit only. Out-of-Pocket Maximum: Initial: **Excluded** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
Office Diagnostic Services: Lab and x-ray services performed in the Physician office.		
► Lab	100% Coverage of Vantage Allowable. Not subject to In-Network Medical Deductible.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
► Specified other lab **Requires Pre-Authorization.**	100% Coverage of Vantage Allowable. Not subject to In-Network Medical Deductible. Contact the Plan for details.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
► X-rays, other office procedures[1], and diagnostic services, excluding major diagnostic testing. **[1]May require Pre-Authorization.**	100% Coverage of Vantage Allowable. Not subject to In-Network Medical Deductible.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.

* If you receive treatment from an Out-of-Network Provider for non-NSA Covered Services, you may be Balance-Billed. See Out-of-Network Coverage section in Section II for more information. In-Network Providers cannot Balance Bill Members. Most non-Emergency Covered Services rendered by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

Maternity-Related Services (continued)

COVERED SERVICE	IN-NETWORK	OUT-OF-NETWORK*
Outpatient Hospital Services: ► Major diagnostic testing (See list of services in the Outpatient Hospital Services category.) **Requires Pre-Authorization**.	100% Coverage of Vantage Allowable less the major diagnostic Co-payment per test, whether the test is performed in an office or outpatient setting. Out-of-Pocket Maximum: Initial: **Included** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
► Ultrasounds ▪ Initial ultrasounds Four (4) maternity-related ultrasounds.	100% Coverage of Vantage Allowable. Not subject to In-Network Medical Deductible.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
▪ Additional ultrasounds Ultrasounds in excess of the four (4) initial maternity-related ultrasounds. **Requires Pre-Authorization.**	100% Coverage of Vantage Allowable less the applicable major diagnostic Co-payment per test, whether the test is performed in an office or outpatient setting. Out-of-Pocket Maximum: Initial: **Included** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.

* If you receive treatment from an Out-of-Network Provider for non-NSA Covered Services, you may be Balance-Billed. See Out-of-Network Coverage section in Section II for more information. In-Network Providers cannot Balance Bill Members. Most non-Emergency Covered Services rendered by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

Maternity-Related Services (continued)

COVERED SERVICE	IN-NETWORK	OUT-OF-NETWORK*
Delivery and Post-Delivery Care: ▪ Delivery Includes care for mother and newborn. **Requires Pre-Authorization.**	100% Coverage of Vantage Allowable less the applicable inpatient Co-payment per day, up to a maximum per admission. Out-of-Pocket Maximum: Initial: **Included** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
▪ Physician Services **Requires Pre-Authorization.**	100% Coverage of Vantage Allowable. Subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
▪ Nursery Care for baby covered from date of birth through mother's date of discharge.	100% Coverage of Vantage Allowable. Subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
▪ Inpatient care for newborn See details in Section VI, Eligibility for Coverage **Requires Pre-Authorization.**	100% Coverage of Vantage Allowable less the applicable inpatient Co-payment per day, up to a maximum per admission. Out-of-Pocket Maximum: Initial: **Included** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.

* If you receive treatment from an Out-of-Network Provider for non-NSA Covered Services, you may be Balance-Billed. See Out-of-Network Coverage section in Section II for more information. In-Network Providers cannot Balance Bill Members. Most non-Emergency Covered Services rendered by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

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 Primary Care Provider.

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., In-Network Cost Share will not apply to wellness and preventive care In-Network Covered Services). Certain Covered Services listed in this Section may not always be classified as wellness and preventive care benefits and will be subject to the Cost Share as noted below. PPACA wellness and preventive care services are listed online at the following websites:

U.S. Preventive Services Task Force
http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
http://www.cdc.gov/vaccines/hcp/acip-recs/index.html

Health Resources and Services Administration
http://www.hrsa.gov/index.html

Preventive Prescription Drugs are listed in the Plan Drug Formulary and are labeled as Tier VI. There is no Cost Share for Preventive Prescription Drugs.

COVERED SERVICE	IN-NETWORK	OUT-OF-NETWORK*
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 and UA.	100% Coverage of Vantage Allowable. Not subject to In-Network Medical Deductible.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Not subject to Out-of-Network Medical Deductible.
► **Colorectal Cancer Screening:** ▪ Fecal immunochemical test for blood (FIT): One (1) every year as part of the routine physical exam. ▪ CT or capsule colonography or flexible sigmoidoscopy: One (1) every five (5) years for ages 45 and over. ▪ Cologuard Test (fecal DNA): One (1) every three (3) years for low or average risk Members ages 45 and over. ▪ Screening Colonoscopy: One (1) every ten (10) years for ages 45 and over. High risk Members may be screened more frequently.	100% Coverage of Vantage Allowable. Not subject to In-Network Deductible. (Any diagnostic colorectal exam or testing is subject to the applicable In-Network Cost Share.)	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Not subject to Out-of-Network Medical Deductible. See Cost Share Schedule. (Any diagnostic colorectal exam or testing: 50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.)

* If you receive treatment from an Out-of-Network Provider for non-NSA Covered Services, you may be Balance-Billed. See Out-of-Network Coverage section in Section II for more information. In-Network Providers cannot Balance Bill Members. Most non-Emergency Covered Services rendered by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

Wellness & Preventive Care (continued)

COVERED SERVICE	IN-NETWORK	OUT-OF-NETWORK*
Immunizations & Vaccines:	100% Coverage of Vantage Allowable. Not subject to In-Network Medical Deductible.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Not subject to Out-of-Network Medical Deductible.
Children's Health: ► Seven (7) visits per Member per Benefit Period for 0 to 12 months of age. ► Five (5) 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. Not subject to In-Network Medical Deductible.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Not subject to Out-of-Network Medical Deductible.
Men's Health: ► One (1) routine prostate test (PSA) per Member per Benefit Period. ► One (1) digital rectal examination for men over age 50 and as medically necessary for men ages 40-50.	100% Coverage of Vantage Allowable. Not subject to In-Network Medical Deductible.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Not subject to Out-of-Network Medical Deductible.
Women's Health:		
► **Anxiety screening** Screening for anxiety in adolescent and adult women, including those who are pregnant or postpartum.	100% Coverage of Vantage Allowable. Not subject to In-Network Deductible.	Member pays Out-of-Network Co-insurance. Not subject to Out-of-Network Deductible. See Cost Share Schedule.
► **BRCA 1 AND BRCA 2 genetic testing Requires Pre-Authorization.**	100% Coverage of Vantage Allowable. Not subject to In-Network Deductible.	Member pays Out-of-Network Co-insurance. Not subject to Out-of-Network Deductible. See Cost Share Schedule.
► **Routine pelvic examination:** Includes one (1) routine Pap test per Member per Benefit Period.	100% Coverage of Vantage Allowable. Not subject to In-Network Medical Deductible. (Any gynecological examination other than the routine pelvic exam and PAP test is subject to the In-Network Medical Deductible and is included in the Initial In-Network Out-of-Pocket Maximum.)	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Not subject to Out-of-Network Medical Deductible. (Any gynecological examination other than the routine pelvic exam and PAP test: 50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.)

* If you receive treatment from an Out-of-Network Provider for non-NSA Covered Services, you may be Balance-Billed. See Out-of-Network Coverage section in Section II for more information. In-Network Providers cannot Balance Bill Members. Most non-Emergency Covered Services rendered by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

Wellness & Preventive Care (continued)

COVERED SERVICE	IN-NETWORK	OUT-OF-NETWORK*
► **Preventive Screening Mammogram:** Including but not limited to digital breast tomosynthesis (DBT). ▪ One (1) baseline mammogram for any woman who is 35-39 years of age. ▪ One (1) annual mammogram (DBT preferred modality) starting at age thirty (30) and one (1) annual MRI starting at age twenty-five for women with a hereditary susceptibility from pathogenic mutation carrier status or prior chest wall radiation. ▪ One (1) annual mammogram (DBT preferred modality) and access to supplemental imaging (MRI preferred modality) starting at age thirty-five upon recommendation by a PCP if the woman has a predicted lifetime risk greater than twenty percent by any validated model published in peer review medical literature. ▪ Annual mammography (DBT preferred modality) for any woman who is 40 years of age, or older.	100% Coverage of Vantage Allowable. Not subject to In-Network Medical Deductible.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Not subject to Out-of-Network Medical Deductible.
Vantage Wellness Program (administered by Affinity Health Network): Vantage offers the following four (4) wellness incentive programs: ► Health Maintenance; ► Tobacco Cessation; ► Weight Loss; and ► Combination Weight Loss and Tobacco Cessation.	100% Coverage of Vantage Allowable for Affinity Health Network services only. Not subject to In-Network Medical Deductible.	No Out-of-Network coverage.

* If you receive treatment from an Out-of-Network Provider for non-NSA Covered Services, you may be Balance-Billed. See Out-of-Network Coverage section in Section II for more information. In-Network Providers cannot Balance Bill Members. Most non-Emergency Covered Services rendered by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

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 (RNFA) will be covered if the same service would be covered when rendered by an advanced practice nurse, physician assistant, or a Physician other than the operating surgeon. Inpatient Hospital services include the rooms, equipment, Drugs, blood transfusions, and medical supplies. The following are also included when the services are rendered by facility-based Physicians: anesthesia, diagnostic services, physical therapy, and psychological testing when ordered by the attending Physician.

COVERED SERVICE	IN-NETWORK	OUT-OF-NETWORK*
Inpatient Semi-Private Room: Including Intensive Care Units (ICU) and Cardiac Care Units (CCU). **Requires Pre-Authorization.**	100% Coverage of Vantage Allowable less the applicable inpatient Co-payment per day, up to a maximum per admission. Out-of-Pocket Maximum: Initial: **Included** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
Physician Services: Surgery, pre- and post-operative medical visits, assistant surgeon services if warranted, approved anesthesia services by CRNA or Physician, consultations, concurrent care, and in-hospital visits. **Requires Pre-Authorization.**	100% Coverage of Vantage Allowable. Subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.

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	IN-NETWORK	OUT-OF-NETWORK*
Ambulatory Surgery Unit (ASU) or Outpatient Surgery: **Requires Pre-Authorization.**	100% Coverage of Vantage Allowable less the applicable ASU/ outpatient surgery Co-payment. Out-of-Pocket Maximum: Initial: **Included** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
Physician Services: Surgery, pre- and post-operative medical visits, assistant surgeon services if warranted, approved anesthesia services by CRNA or Physician, and consultations. **Requires Pre-Authorization.**	100% Coverage of Vantage Allowable. Subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.

* If you receive treatment from an Out-of-Network Provider for non-NSA Covered Services, you may be Balance-Billed. See Out-of-Network Coverage section in Section II for more information. In-Network Providers cannot Balance Bill Members. Most non-Emergency Covered Services rendered by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

Outpatient Hospital Services

COVERED SERVICE	IN-NETWORK	OUT-OF-NETWORK*
Observation Stay: ► Facility	100% Coverage of Vantage Allowable less the applicable inpatient Co-payment per day, up to a maximum per admission. Out-of-Pocket Maximum: Initial: **Included** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
► Physician Services **Requires Pre-Authorization.**	100% Coverage of Vantage Allowable. Subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
Major Diagnostic Testing: Including, but not limited to: ► 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 the applicable major diagnostic Co-payment per test, whether the test is performed in an office or outpatient setting. Out-of-Pocket Maximum: Initial: **Included** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.

* If you receive treatment from an Out-of-Network Provider for non-NSA Covered Services, you may be Balance-Billed. See Out-of-Network Coverage section in Section II for more information. In-Network Providers cannot Balance Bill Members. Most non-Emergency Covered Services rendered by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

Outpatient Hospital Services (continued)

COVERED SERVICE	IN-NETWORK	OUT-OF-NETWORK*
Other Hospital Outpatient Services: ► Lab	100% Coverage of Vantage Allowable. Not subject to In-Network Medical Deductible. (Lab services performed in the emergency room are subject to In-Network Medical Deductible and are included in the Initial In-Network Out-of-Pocket Maximum.)	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
► Specified other lab **Requires Pre-Authorization.**	100% Coverage of Vantage Allowable. Not subject to In-Network Medical Deductible. Contact the Plan for details. (Lab services performed in the emergency room are subject to In-Network Medical Deductible and are included in the Initial In-Network Out-of-Pocket Maximum.)	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
► X-rays	100% Coverage of Vantage Allowable. Out-of-Pocket Maximum: Initial: **Included** PPACA: **Included** Not subject to In-Network Medical Deductible.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
► Diagnostic tests, injections, infusions and other Hospital outpatient services not listed elsewhere in this Section IV and not performed in an office visit setting. **Requires Pre-Authorization.**	100% Coverage of Vantage Allowable. Out-of-Pocket Maximum: Initial: **Included** PPACA: **Included** Subject to In-Network Medical Deductible.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.

* If you receive treatment from an Out-of-Network Provider for non-NSA Covered Services, you may be Balance-Billed. See Out-of-Network Coverage section in Section II for more information. In-Network Providers cannot Balance Bill Members. Most non-Emergency Covered Services rendered by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

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**. Payments of claims for Emergency Medical Services rendered by a Non-Participating Health Care Provider are not made directly to the Member.

Examples of Emergency criteria include:

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

If you receive Emergency Medical Services from any Out-of-Network Provider, including ambulance services, your Cost Share is based on a Qualified Payment Amount (QPA) and you cannot be Balance-Billed.

COVERED SERVICE	IN-NETWORK	OUT-OF-NETWORK*
Emergency Room Service and Supplies:		
► If treated and released within 24 hours of onset of Illness or injury.	100% Coverage of the Vantage Allowable less Emergency room Co-payment for each visit. Out-of-Pocket Maximum: Initial: **Included** PPACA: **Included** Not subject to Medical Deductible. See Cost Share Schedule.	100% Coverage of the Vantage Allowable less Emergency room Co-payment for each visit. Out-of-Pocket Maximum: Initial: **Included** PPACA: **Included** Not subject to Medical Deductible. See Cost Share Schedule.
► If admitted within 24 hours subsequent to treatment.	100% Coverage of the Vantage Allowable. Emergency room Co-payment waived if admitted. Not subject to Medical Deductible.	100% Coverage of Vantage Allowable. Emergency room Co-payment waived if admitted. Not subject to Medical Deductible.
► Physician Services	100% Coverage of Vantage Allowable. Subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
Ambulance Service: Ambulance service provided by a professional ambulance service for local ground transportation to a Hospital for a covered medical Emergency, including the authorized transportation of a Newborn and Temporarily Medically Disabled Mother. Air ambulance services are available only if this type of Ambulance Service is requested by policing or medical authorities at the site in an Emergency situation or the Member is in a location that cannot be reached by a ground ambulance.	100% Coverage of the Vantage Allowable less applicable Ambulance Co-payment for each visit. Out-of-Pocket Maximum: Initial: **Included** PPACA: **Included** Not subject to Medical Deductible. See Cost Share Schedule.	100% Coverage of the Vantage Allowable less applicable Ambulance Co-payment for each visit. Out-of-Pocket Maximum: Initial: **Included** PPACA: **Included** Not subject to Medical Deductible. See Cost Share Schedule.

* If you receive treatment from an Out-of-Network Provider for non-NSA Covered Services, you may be Balance-Billed. See Out-of-Network Coverage section in Section II for more information. In-Network Providers cannot Balance Bill Members. Most non-Emergency Covered Services rendered by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

Emergency Medical Services (continued)

COVERED SERVICE	IN-NETWORK	OUT-OF-NETWORK*
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 if Medically Necessary. **Requires Pre-Authorization.**	100% Coverage of the Vantage Allowable less applicable Ambulance Co-payment for each visit. Out-of-Pocket Maximum: Initial: **Included** PPACA: **Included** Not subject to Medical Deductible. See Cost Share Schedule.	100% Coverage of the Vantage Allowable less applicable Ambulance Co-payment for each visit. Out-of-Pocket Maximum: Initial: **Included** PPACA: **Included** Not subject to Medical Deductible. See Cost Share Schedule.

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.

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.

After the Member's In-Network Durable Medical Equipment and Supplies Co-insurance reaches $5,000 of the Vantage Allowable, Eligible Charges for Durable Medical Equipment and Supplies Eligible Charges are covered by the Plan at 100% of the Vantage Allowable for the remainder of the Benefit Period.

COVERED SERVICE	IN-NETWORK	OUT-OF-NETWORK*
Diabetic Supplies: Limited to Glucocard Shine Meter Kit blood glucose monitoring system (1 meter per Benefit Period) and Glucocard Shine Test Strips (50-count packages) manufactured by ARKRAY USA, Inc. Members may receive up to a 100-day supply per order.		
► DeSiard Pharmacy Network pharmacies	100% Coverage of Vantage Allowable. Not subject to In-Network Medical Deductible.	Not applicable.
► All other Providers	80% Coverage of Vantage Allowable. Member pays 20% of Vantage Allowable. Out-of-Pocket Maximum: Initial: **Excluded** PPACA: **Included** Subject to In-Network Medical Deductible.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.

* If you receive treatment from an Out-of-Network Provider for non-NSA Covered Services, you may be Balance-Billed. See Out-of-Network Coverage section in Section II for more information. In-Network Providers cannot Balance Bill Members. Most non-Emergency Covered Services rendered by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

Durable Medical Equipment and Supplies (continued)

COVERED SERVICE	IN-NETWORK	OUT-OF-NETWORK*
Durable Medical Equipment and Supplies as defined in "Definitions" (Section III): ► Oxygen and rental of equipment for its administration. **Requires Pre-Authorization.** ► 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. Out-of-Pocket Maximum: Initial: **Excluded** PPACA: **Included** Subject to In-Network Medical Deductible.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
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 cover a mid-level digital hearing aid for each ear with hearing loss not to exceed one every thirty-six (36) months. If a higher-level hearing aid is received, the Member is not only responsible for the applicable mid-level hearing aid co-insurance, but also for the additional cost of the higher-level hearing aid. The additional cost is the difference between the price of the higher-level hearing aid and the Vantage Allowable of the mid-level hearing aid. **Requires Pre-Authorization.**	80% Coverage of Vantage Allowable. Member pays 20% of Vantage Allowable. Out-of-Pocket Maximum: Initial: **Excluded** PPACA: **Included** Subject to In-Network Medical Deductible.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
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. Training, supplies and other services specific to an insulin pump are covered at 80% of the Vantage Allowable. **Requires Pre-Authorization.**	80% Coverage of Vantage Allowable. Member pays 20% of Vantage Allowable. Out-of-Pocket Maximum: Initial: **Excluded** PPACA: **Included** Subject to In-Network Medical Deductible.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.

* If you receive treatment from an Out-of-Network Provider for non-NSA Covered Services, you may be Balance-Billed. See Out-of-Network Coverage section in Section II for more information. In-Network Providers cannot Balance Bill Members. Most non-Emergency Covered Services rendered by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

Durable Medical Equipment and Supplies (continued)

COVERED SERVICE	IN-NETWORK	OUT-OF-NETWORK*
Orthotic Devices: Repair or replacement of the orthotic device is covered only within a reasonable time period from the date of purchase subject to the expected lifetime of the device. The benefit for deluxe devices will be based on the Vantage Allowable for standard devices. Deluxe devices solely for comfort or convenience will only be provided when documented to be Medically Necessary. **Requires Pre-Authorization.**	80% Coverage of Vantage Allowable. Member pays 20% of Vantage Allowable. Out-of-Pocket Maximum: Initial: **Excluded** PPACA: **Included** Subject to In-Network Medical Deductible.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
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. **Requires Pre-Authorization.**	80% Coverage of Vantage Allowable. Member pays 20% of Vantage Allowable. Out-of-Pocket Maximum: Initial: **Excluded** PPACA: **Included** Subject to In-Network Medical Deductible.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.

After-Hours/Walk-In Clinics and Urgent Care Centers

Prior to receiving services at an After-Hours/Walk-In Clinic or Urgent Care Center, please confirm the specialty or provider type in the Provider Directory online at *www.VHP-StateGroup.com* or contact Vantage's Member Services department. Your Cost Share may differ based on the Provider, specialty or facility type.

COVERED SERVICE	IN-NETWORK	OUT-OF-NETWORK*
After-Hours/Walk-In Clinics:	100% Coverage of Vantage Allowable less the applicable Primary Care Provider office visit Co-payment. Out-of-Pocket Maximum: Initial: **Excluded** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
Urgent Care Centers: **Follow-up visits require Pre-Authorization.**	100% Coverage of Vantage Allowable less the Urgent Care Co-payment. Out-of-Pocket Maximum: Initial: **Excluded** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.

* If you receive treatment from an Out-of-Network Provider for non-NSA Covered Services, you may be Balance-Billed. See Out-of-Network Coverage section in Section II for more information. In-Network Providers cannot Balance Bill Members. Most non-Emergency Covered Services rendered by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

Extended Care Facilities

COVERED SERVICE	IN-NETWORK	OUT-OF-NETWORK*
Long-Term Acute Care Facility (LTAC) (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 the extended care facility Co-payment per day, up to a maximum per admission. Out-of-Pocket Maximum: Initial: **Included** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
Rehabilitation Facility (Rehab) (post-acute Illness or injury, non-custodial): Semi-private room and board and Medically Necessary services and supplies. 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 the extended care facility Co-payment per day, up to a maximum per admission. Out-of-Pocket Maximum: Initial: **Included** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
Skilled Nursing Facility (SNF) (post-Hospital, non-custodial): Semi-private room and board and Medically Necessary services and supplies. 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 the extended care facility Co-payment per day, up to a maximum per admission. See Cost Share Schedule. Out-of-Pocket Maximum: Initial: **Included** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
Physician Services:	100% Coverage of Vantage Allowable. Subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.

* If you receive treatment from an Out-of-Network Provider for non-NSA Covered Services, you may be Balance-Billed. See Out-of-Network Coverage section in Section II for more information. In-Network Providers cannot Balance Bill Members. Most non-Emergency Covered Services rendered by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

Other Covered Services

COVERED SERVICE	IN-NETWORK	OUT-OF-NETWORK*
Acupuncture: Limited to twelve (12) visits per Benefit Period. **Requires Pre-Authorization.**	80% Coverage of Vantage Allowable. Member pays 20% of Vantage Allowable. Out-of-Pocket Maximum: Initial: **Included** PPACA: **Included** Subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
Allergenic Testing: Diagnostic testing and immuno-therapy. **Requires Pre-Authorization.**	80% Coverage of Vantage Allowable. Member pays 20% of Vantage Allowable. Out-of-Pocket Maximum: Initial: **Included** PPACA: **Included** Subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
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. **Requires Pre-Authorization.**	**Facility:** 100% Coverage of Vantage Allowable less the applicable ASU/ outpatient surgery or the observation inpatient Co-payment per day, up to a maximum per admission. Out-of-Pocket Maximum: Initial: **Included** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule. **Physician:** 100% Coverage of Vantage Allowable. Subject to In-Network Medical Deductible.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible. 50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.

* If you receive treatment from an Out-of-Network Provider for non-NSA Covered Services, you may be Balance-Billed. See Out-of-Network Coverage section in Section II for more information. In-Network Providers cannot Balance Bill Members. Most non-Emergency Covered Services rendered by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

Other Covered Services (continued)

COVERED SERVICE	IN-NETWORK	OUT-OF-NETWORK*
Attention Deficit/Hyperactivity Disorder: Diagnosis and treatment of attention deficit/hyperactivity disorder.	**Office Visits:** 100% Coverage of Vantage Allowable less the applicable Primary Care Provider or Specialty Care office visit Co-payment. Out-of-Pocket Maximum: Initial: **Excluded** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule. **Other Services:** 80% Coverage of Vantage Allowable. Member pays 20% of Vantage Allowable. Out-of-Pocket Maximum: Initial: **Included** PPACA: **Included** Subject to In-Network Medical Deductible. See Cost Share Schedule. **Requires Pre-Authorization.**	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible. 50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
Autism Spectrum Disorders: Member must be under the age of twenty-one (21). 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. **Requires Pre-Authorization.**	100% Coverage of Vantage Allowable less the applicable Primary Care Provider office visit Co-payment. Out-of-Pocket Maximum: Initial: **Excluded** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.

* If you receive treatment from an Out-of-Network Provider for non-NSA Covered Services, you may be Balance-Billed. See Out-of-Network Coverage section in Section II for more information. In-Network Providers cannot Balance Bill Members. Most non-Emergency Covered Services rendered by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

Other Covered Services (continued)

COVERED SERVICE	IN-NETWORK	OUT-OF-NETWORK*
Bone Density (Bone Mass Measurement): ▪ One (1) preventive bone density screening for women over age 50.	100% Coverage of the Vantage Allowable. Not subject to In-Network Medical Deductible.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Not subject to Out-of-Network Medical Deductible.
▪ All other bone density tests for the following Members: (a) An estrogen-deficient woman at clinical risk of osteoporosis who is considering treatment; (b) An individual receiving long-term steroid therapy; or (c) An individual being monitored to assess the response to or efficacy of approved osteoporosis drug therapies. **Requires Pre-Authorization.**	100% Coverage of the Vantage Allowable. Subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
Cardiac Rehabilitation: Cardiac (heart) rehab services are limited to a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks. These services must be initiated within 3 months after hospital discharge. **Requires Pre-Authorization.**	100% Coverage of Vantage Allowable less the applicable Specialty Care office visit Co-payment. Out-of-Pocket Maximum: Initial: **Excluded** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
Anti-cancer/ Radiation Therapy: Includes intravenous, injected, and oral cancer medications. **Requires Pre-Authorization.**	**Office Visits:** 100% Coverage of Vantage Allowable less the applicable office visit Co-payment. Out-of-Pocket Maximum: Initial: **Excluded** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule. **Outpatient:** 100% Coverage of Vantage Allowable. Subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible. 50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.

* If you receive treatment from an Out-of-Network Provider for non-NSA Covered Services, you may be Balance-Billed. See Out-of-Network Coverage section in Section II for more information. In-Network Providers cannot Balance Bill Members. Most non-Emergency Covered Services rendered by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

Other Covered Services (continued)

COVERED SERVICE	IN-NETWORK	OUT-OF-NETWORK*
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 the applicable Primary Care Provider or Specialty Care office visit Co-payment. Out-of-Pocket Maximum: Initial: **Excluded** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule. **Outpatient Surgery:** 100% Coverage of Vantage Allowable less the applicable ASU/ outpatient surgery Co-payment. Out-of-Pocket Maximum: Initial: **Included** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule. **Requires Pre-Authorization.** **Other Hospital Outpatient Services for Cleft Lip/Palate:** 100% Coverage of the Vantage Allowable. Out-of-Pocket Maximum: Initial: **Included** PPACA: **Included** Subject to In-Network Medical Deductible. **Requires Pre-Authorization.**	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible. 50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible. 50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
COVID-19 Tests and Treatments: Includes diagnostic tests, antibody tests and antiviral drugs when ordered by a Health Care Provider for the purpose of making clinical decisions or treating a Member suspected of having COVID-19.	Member pays applicable cost share.	Member pays applicable cost share.

* If you receive treatment from an Out-of-Network Provider for non-NSA Covered Services, you may be Balance-Billed. See Out-of-Network Coverage section in Section II for more information. In-Network Providers cannot Balance Bill Members. Most non-Emergency Covered Services rendered by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

Other Covered Services (continued)

COVERED SERVICE	IN-NETWORK	OUT-OF-NETWORK*
Diabetes Management: Outpatient self-management training (including the initial self-monitoring 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. Additional training may be covered based on Medical Necessity. Diabetic supplies are limited to a specific manufacturer, products and/or brands. Maximum of ten (10) visits during the initial Benefit Period and four (4) visits per Benefit Period thereafter. **Requires Pre-Authorization.**	100% Coverage of Vantage Allowable less the applicable Primary Care Provider office visit Co-payment. Out-of-Pocket Maximum: Initial: **Excluded** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
Diagnostic Mammogram:	100% Coverage of Vantage Allowable. Not subject to In-Network Deductible.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Not subject to Out-of-Network Medical Deductible.
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 the Vantage Allowable. Subject to In-Network Medical Deductible.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
Disposable Medical Equipment or Supplies: Disposable medical equipment or supplies (excluding Diabetic Supplies) related to and necessary for the administration of Prescription Drugs, such as syringes and needles, and other disposable medical equipment or supplies which have a primary medical purpose are covered and will be subject to reasonable quantity limits as determined by Vantage. **Requires Pre-Authorization**	80% Coverage of Vantage Allowable. Member pays 20% of Vantage Allowable. Out-of-Pocket Maximum: Initial: **Excluded** PPACA: **Included** Subject to In-Network Medical Deductible.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
Genetic or Molecular Cancer Testing: Includes, but not limited to, coverage for tumor mutation testing, next generation sequencing, hereditary germline mutation testing, pharmacogenomic testing, whole exome, genome sequencing and biomarker testing. **Requires Pre-Authorization.**	80% Coverage of Vantage Allowable. Member pays 20% of Vantage Allowable. Subject to In-Network Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Deductible. See Cost Share Schedule.

* If you receive treatment from an Out-of-Network Provider for non-NSA Covered Services, you may be Balance-Billed. See Out-of-Network Coverage section in Section II for more information. In-Network Providers cannot Balance Bill Members. Most non-Emergency Covered Services rendered by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

Other Covered Services (continued)

COVERED SERVICE	IN-NETWORK	OUT-OF-NETWORK*
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 the Vantage Allowable. Subject to In-Network Medical Deductible.	No coverage for Out-of-Network Providers.
Hospice Care: Medically Necessary services and supplies of Participating Provider. **Requires Pre-Authorization**.	100% Coverage of the Vantage Allowable. Subject to In-Network Medical Deductible.	No coverage for Out-of-Network Providers.
Interpreter Services for the Deaf or Hard of Hearing: Includes coverage for expenses incurred by any Member who is deaf or hard of hearing 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. Out-of-Pocket Maximum: Initial: **Included** PPACA: **Included** Subject to In-Network Medical Deductible.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
Intrauterine Device (IUD) for Birth Control: Contraceptive device, such as Mirena, Paragard, or Skyla, furnished and administered by a Primary Care Provider or OB/GYN. Coverage includes insertion and/or removal of device.	100% Coverage of Vantage Allowable. Not subject to In-Network Deductible.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Not subject to Out-of-Network Medical Deductible.
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. Low protein food products shall not include a food that is naturally low in protein. **Requires Pre-Authorization.**	80% Coverage of Vantage Allowable. Member pays 20% of Vantage Allowable. Out-of-Pocket Maximum: Initial: **Included** PPACA: **Included** Subject to In-Network Medical Deductible.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.

* If you receive treatment from an Out-of-Network Provider for non-NSA Covered Services, you may be Balance-Billed. See Out-of-Network Coverage section in Section II for more information. In-Network Providers cannot Balance Bill Members. Most non-Emergency Covered Services rendered by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

Other Covered Services (continued)

COVERED SERVICE	IN-NETWORK	OUT-OF-NETWORK*
Nutritional Counseling: Maximum of four (4) visits per Benefit Period. **Requires Pre-Authorization.**	100% Coverage of Vantage Allowable less the applicable Primary Care Provider office visit Co-payment. Out-of-Pocket Maximum: Initial: **Excluded** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
Outpatient Rehabilitation Services: ► **Occupational and Speech Therapy** Services after Illness or injury to restore pre-existing function. 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.**	100% Coverage of Vantage Allowable less the applicable occupational and speech therapy Co-payment. Out-of-Pocket Maximum: Initial: **Excluded** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
► **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. **Requires Pre-Authorization.**	100% Coverage of Vantage Allowable less the applicable physical therapy Co-payment. Out-of-Pocket Maximum: Initial: **Excluded** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
Routine Foot Care: Routine foot care for Members who have a diabetes diagnosis and diabetes-related nerve damage. Maximum of one visit per Benefit Period.	100% Coverage of Vantage Allowable less the applicable Primary Care Provider or Specialty Care office visit Co-payment. Out-of-Pocket Maximum: Initial: **Excluded** PPACA: **Included** Not subject to In-Network Medical Deductible.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.

* If you receive treatment from an Out-of-Network Provider for non-NSA Covered Services, you may be Balance-Billed. See Out-of-Network Coverage section in Section II for more information. In-Network Providers cannot Balance Bill Members. Most non-Emergency Covered Services rendered by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

Other Covered Services (continued)

COVERED SERVICE	IN-NETWORK	OUT-OF-NETWORK*
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 the applicable Primary Care Provider office visit Co-payment. Out-of-Pocket Maximum: Initial: **Excluded** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
Telemedicine Covered telehealth services including consultation, diagnosis, and treatment through electronic exchange when a PCP or Specialist is not in the same location as the member (within the United States), including the member's home. This benefit does not cover e-mail messages, instant messages (SMS, text, etc.), or telephone calls made to or received from your Provider.	100% Coverage of Vantage Allowable less the applicable Primary Care Provider or Specialty Care office visit Co-payment. Out-of-Pocket Maximum: Initial: **Excluded** PPACA: **Included** Not subject to In-Network Medical Deductible.	No Out-of-Network coverage.
Temporomandibular Joint (TMJ) Disorder: Diagnostic, therapeutic, or surgical procedures related to TMJ and associated musculature and neurological conditions. **Requires Pre-Authorization.**	100% Coverage of Vantage Allowable less the applicable ASU/ outpatient surgery or the observation or inpatient Co-payment per day, up to a maximum per admission. Out-of-Pocket Maximum: Initial: **Included** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.

* If you receive treatment from an Out-of-Network Provider for non-NSA Covered Services, you may be Balance-Billed. See Out-of-Network Coverage section in Section II for more information. In-Network Providers cannot Balance Bill Members. Most non-Emergency Covered Services rendered by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

Supplementary Benefits
(NO OUT-OF-NETWORK COVERAGE)

Subject to In-Network Medical Deductible and excluded from the Initial In-Network Medical Out-of-Pocket Maximum and excluded in the PPACA In-Network Out-of-Pocket Maximum.

COVERED SERVICE	IN-NETWORK
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. Subject to the In-Network Medical Deductible. **Physician**: 60% Coverage of Vantage Allowable. Member pays 40% of Vantage Allowable. Subject to the In-Network Medical Deductible.

Mental Health and Alcohol & Chemical Dependency Services

COVERED SERVICE	IN-NETWORK	OUT-OF-NETWORK*
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 the applicable Primary Care Provider office visit Co-payment. Out-of-Pocket Maximum: Initial: **Excluded** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule. **Physician:** 100% Coverage of Vantage Allowable less the applicable Primary Care Provider or Specialty Care office visit Co-payment. Out-of-Pocket Maximum: Initial: **Excluded** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible. 50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.

* If you receive treatment from an Out-of-Network Provider for non-NSA Covered Services, you may be Balance-Billed. See Out-of-Network Coverage section in Section II for more information. In-Network Providers cannot Balance Bill Members. Most non-Emergency Covered Services rendered by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

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Mental Health and Alcohol & Chemical Dependency Services (continued)

COVERED SERVICE	IN-NETWORK	OUT-OF-NETWORK*
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 the applicable inpatient Co-payment per day, up to a maximum per admission. Out-of-Pocket Maximum: Initial: **Included** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
Inpatient Mental Health Physician Services: **Requires Pre-Authorization.**	100% Coverage of Vantage Allowable. Subject to In-Network Medical Deductible.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
Outpatient Alcohol & Chemical Dependency:	**Facility:** 100% Coverage of Vantage Allowable less the applicable Primary Care Provider office visit Co-payment. Out-of-Pocket Maximum: Initial: **Excluded** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule. **Physician:** 100% Coverage of Vantage Allowable less the applicable Primary Care Provider or Specialty Care office visit Co-payment. Out-of-Pocket Maximum: Initial: **Excluded** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible. 50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.

* If you receive treatment from an Out-of-Network Provider for non-NSA Covered Services, you may be Balance-Billed. See Out-of-Network Coverage section in Section II for more information. In-Network Providers cannot Balance Bill Members. Most non-Emergency Covered Services rendered by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

Mental Health and Alcohol & Chemical Dependency Services (continued)

COVERED SERVICE	IN-NETWORK	OUT-OF-NETWORK*
Inpatient Alcohol & Chemical Dependency: **Requires Pre-Authorization.**	100% Coverage of Vantage Allowable less the applicable inpatient Co-payment per day, up to a maximum per admission. Out-of-Pocket Maximum: Initial: **Included** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
Inpatient Alcohol & Chemical Dependency Physician Services: **Requires Pre-Authorization.**	100% Coverage of Vantage Allowable. Subject to In-Network Medical Deductible.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.

* If you receive treatment from an Out-of-Network Provider for non-NSA Covered Services, you may be Balance-Billed. See Out-of-Network Coverage section in Section II for more information. In-Network Providers cannot Balance Bill Members. Most non-Emergency Covered Services rendered by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

Vision Services

COVERED SERVICE	IN-NETWORK	OUT-OF-NETWORK*
Vision Exam for Children: One (1) visit annually for Children age 18 and younger. Includes dilation (refraction).	100% Coverage of Vantage Allowable less the Specialty Care office visit Co-payment. Out-of-Pocket Maximum: Initial: **Excluded** PPACA: **Included** Not subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
Vision Exam for Adults: One (1) visit annually. Includes dilation (refraction).	100% Coverage of Vantage Allowable less the Specialty Care office visit Co-payment. Out-of-Pocket Maximum: Initial: **Excluded** PPACA: **Excluded** Not subject to In-Network Medical Deductible. See Cost Share Schedule.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Subject to Out-of-Network Medical Deductible.
Glasses and Contact Lenses for Children: One (1) pair of basic frames and lenses or twelve-month (12-month) supply of contact lenses per Benefit Period for Children age 18 and younger. Maximum benefit of **$100** each Benefit Period.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Out-of-Pocket Maximum: Initial: **Excluded** PPACA: **Included** Not subject to In-Network Deductible.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Not subject to Out-of-Network Medical Deductible.
Glasses and Contact Lenses for Adults: One (1) pair of basic frames and lenses or twelve-month (12-month) supply of contact lenses per Benefit Period. Maximum benefit of **$100** each Benefit Period.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Out-of-Pocket Maximum: Initial: **Excluded** PPACA: **Excluded** Not subject to In-Network Deductible.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Not subject to Out-of-Network Medical Deductible.

* If you receive treatment from an Out-of-Network Provider for non-NSA Covered Services, you may be Balance-Billed. See Out-of-Network Coverage section in Section II for more information. In-Network Providers cannot Balance Bill Members. Most non-Emergency Covered Services rendered by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

Dental Services

COVERED SERVICE	IN-NETWORK	OUT-OF-NETWORK*
Preventive Dental Exam and Cleaning: Two (2) visits annually.	100% Coverage of Vantage Allowable. Not subject to In-Network Medical Deductible.	100% Coverage of Vantage Allowable. Member may be Balance-Billed. Not subject to Out-of-Network Medical Deductible.
Preventive Bitewing X-rays: One (1) set of x-rays annually.	100% Coverage of Vantage Allowable. Not subject to In-Network Medical Deductible.	100% Coverage of Vantage Allowable. Member may be Balance-Billed. Not subject to Out-of-Network Medical Deductible.
Comprehensive Dental Services: View a complete list of Comprehensive Dental Services at: *https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plan-codes/2014/brochures/MetLife.pdf* ► **Basic Dental:** Includes diagnostic bitewing x-rays. ► **Intermediate/Major Dental** **Maximum annual benefit of $500 for all members.** **Intermediate/Major Dental Services require Pre-Authorization.**	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Out-of-Pocket Maximum: Children: Initial: **Excluded** PPACA: **Included** Adults: Initial: **Excluded** PPACA: **Excluded** Not subject to In-Network Medical Deductible.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Member may be Balance-Billed. Not subject to Out-of-Network Medical Deductible.
Orthodontia for Children: Medically necessary orthodontia for Children age 18 and younger. **Requires Pre-Authorization.** **Included in the maximum annual benefit of $500 for Comprehensive Dental Services.**	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Out-of-Pocket Maximum: Initial: **Excluded** PPACA: **Included** Not subject to In-Network Medical Deductible.	50% Coverage of Vantage Allowable. Member pays 50% of Vantage Allowable. Member may be Balance-Billed. Not subject to Out-of-Network Medical Deductible.

* If you receive treatment from an Out-of-Network Provider for non-NSA Covered Services, you may be Balance-Billed. See Out-of-Network Coverage section in Section II for more information. In-Network Providers cannot Balance Bill Members. Most non-Emergency Covered Services rendered by Out-of-Network Providers require Pre-Authorization. There is no Out-of-Pocket Maximum for Out-of-Network services.

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

- 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; or (c) the date of the Member's death.

- 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 Management Committee); (c) liver; (d) heart; (e) heart-lung; (f) pancreas; (g) lung (single/double); (h) kidney/pancreas; and (i) small bowel.

- The following tissue transplants are also covered: (a) blood transfusions; (b) autologous parathyroid transplants; (c) corneal transplants; (d) bone and cartilage grafting; (e) skin grafting; and
(f) autologous islet cell transplants.

  Other tissue/solid organ transplant procedures which Vantage determines have become standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures will be considered on a case-by-case basis.

- Immunosuppressive Drugs after Approved Transplant Services are covered under the Prescription Drug benefit and according to the Plan Drug Formulary.

- 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; and (d) services required to keep a donor alive for the transplant.

Member pays Approved Transplant Services Cost Share. See Cost Share Schedule.

Facility: Approved Transplant Services are not subject to the In-Network Deductible, excluded from the Initial In-Network Medical Out-of-Pocket Maximum, and included in the PPACA In-Network Out-of-Pocket Maximum.

Physician: Approved Transplant Services are subject to the In-Network Deductible, excluded from the Initial In-Network Medical Out-of-Pocket Maximum, and included in the PPACA In-Network Out-of-Pocket Maximum.

Approved Transplant Services require Pre-Authorization.

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

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

The Plan Drug Formulary is a comprehensive listing of Drugs covered by this Plan. Vantage reserves the right to make changes to its Plan Drug Formulary consistent with federal and state law and the Food and Drug Administration ("FDA") recommendations. Plan Drug Formulary changes are made at the Benefit Plan effective date, unless immediate action is required by the FDA. All Prescription Drugs included in the Plan Drug Formulary are either approved by the 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, or the USPDI or its successor. Vantage's team of doctors and pharmacists perform a comprehensive review and update of the Plan Drug Formulary annually.

Generally, if you are taking a Drug on our Formulary that was covered at the beginning of the Benefit Period, Vantage will not discontinue or reduce coverage of the Drug during the next Benefit Period except when new adverse information about the safety or effectiveness of a Drug is released. If the Food and Drug Administration (FDA) deems a Drug on our Formulary to be unsafe or the Drug's manufacturer removes the Drug from the market, Vantage will immediately remove the Drug from our Formulary and our Pharmacy Benefit Manager (PBM) will provide notice to Members who take the Drug and their Providers. In the event of a mid-year non-maintenance Formulary change, the printed and web-based versions of the Formulary will be updated as of the effective date of the Formulary change. The updated versions of the printed Formulary will be available upon request. To get updated information about the Drugs covered by Vantage, please contact us at (318) 998-4371 or (844) 833-7504.

Your pharmacy Plan is mandatory generic which means if a brand name Prescription Drug is available as a Generic Drug and you receive the brand name Prescription Drug, you are not only responsible for the applicable Generic Drug Co-payment but also for an additional cost. The additional cost is the difference between the cost of the brand name Prescription Drug and the cost of the available Generic Drug at the time of fill. Generic or brand status, drug tiers, and any applicable restrictions may change monthly.

Certain Tier V Prescription Drugs must be provided by one of the Plan's In-Network participating specialty pharmacies. Specialty pharmacy availability may vary by Drug and the preferred specialty pharmacy is noted in the Plan Drug Formulary beside each Drug name. The preferred specialty pharmacies listed are known suppliers of certain Specialty Drugs. However, a Member may use any pharmacy willing to agree in writing to provide pharmaceutical services and products that meet all the terms and requirements as stated in Vantage's pharmacy benefits manager's contracting agreements, including the same administrative, financial, and professional conditions and a minimum contract term of one year if requested, that apply to all other pharmacies or pharmacists who have been designated as providers under the Plan.

When these specified Prescription Drugs are not provided by one of the In-Network participating specialty pharmacies as listed in the Plan Drug Formulary, 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 the listed specialty pharmacy less the Member's Cost Share. Prescription Drugs provided by the Plan's In-Network participating specialty pharmacies will be subject to the Tier V Prescription Drug Cost Share, are excluded from the Initial In-Network Medical Out-of-Pocket Maximum, and are included in the PPACA In-Network Out-of-Pocket Maximum. Certain Tier V Prescription 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.

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.

Prescription Drugs are covered only if approved by the FDA for use and sale in the United States. Therefore, even if the manufacturer has FDA approval for a Drug, the version produced for foreign markets usually does not meet all of the requirements of the United States approval, and thus it is considered to be unapproved.

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

If you have questions regarding the Plan Drug Formulary, coverage of a Drug, or how to request Plan Drug Formulary exceptions, please call Vantage's Member Services department at (318) 998-4371 or toll-free at (844) 833-7504. You can also view the Plan Drug Formulary, documents providing information on Pre-Authorization, quantity limit, and step therapy requirements, or the Plan Drug Formulary exception process on our website at *www.VHP-StateGroup.com*.

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.

Co-payments are applied to the total cost of the Prescription Drug, including the sales tax.

Some Prescription Drugs require Pre-Authorization. All Tier V Prescription Drugs require Pre-Authorization.

See Section V of this Certificate for applicable Prescription Drug benefit exclusions and limitations.

Member will pay their In-Network Prescription Drug Cost Share when receiving Prescription Drugs from In-Network pharmacies. The Member's Cost Share will not exceed 100% of the Vantage Allowable up to their In-Network Prescription Drug Cost Share.

Prescription Drug Co-payments are excluded from the Initial In-Network Medical Out-of-Pocket Maximum and included in the PPACA In-Network Out-of-Pocket Maximum.

Prescription Drug Benefits (continued) **(NO OUT-OF-NETWORK COVERAGE)**	
Prescription Drug Cost Share: 30-day supply for 1 Co-payment 60-day supply for 2 Co-payments 100-day supply for 3 Co-payments	**Cost Share below is for a 30-day supply**
RETAIL PRESCRIPTION DRUGS	**IN-NETWORK**
Prescription Drug Deductible	**No Prescription Drug Deductible.**
Tier I Prescription Drugs: ▪ DeSiard Pharmacy Network pharmacies ▪ All other In-Network pharmacies	100% Coverage. Member pays **$15** Tier I Co-payment per Tier I Prescription Drug order or refill up to a 30-day supply.
Tier II Prescription Drugs:	Member pays **$40** Tier II Co-payment per Tier II Prescription Drug order or refill up to a 30-day supply.
Tier III Prescription Drugs:	Member pays **$75** Tier III Co-payment per Tier III Prescription Drug order or refill up to a 30-day supply.
Tier IV Prescription Drugs:	Member pays **$100** Tier IV Co-payment for Tier IV Prescription Drug order or refill up to a 30-day supply.
Tier V Prescription Drugs:	Member pays **$150** Tier V Co-payment for Tier V Prescription Drug order or refill up to a 30-day supply.
Tier VI Preventive Prescription Drugs:	100% Coverage.
Diabetic Supplies and Meters at a Pharmacy Limited to Glucocard Shine Meter Kit blood glucose monitoring system (1 meter per Benefit Period) and Glucocard Shine Test Strips (50-count packages) manufactured by ARKRAY USA, Inc. (Members may receive up to a 100-day supply per order from Saint John Pharmacy and DeSiard Pharmacy Network Pharmacies mail order.) ▪ DeSiard Pharmacy Network Pharmacies ▪ All other In-Network pharmacies	 100% Coverage. Applicable Tier Prescription Drug Co-payments apply.
MAIL ORDER PRESCRIPTION DRUGS	**IN-NETWORK**
All Tiers:	See Cost Share Schedule.

Additional Benefits

Continuity Of Care:

In order to ensure continuity of care, Vantage must—

(1) Make a good faith effort to provide written notice of discontinuation of a Health Care Provider thirty (30) days prior to the effective date of the change or otherwise as soon as practicable, to Members who are patients seen on a regular basis by the Health Care Provider or who receive primary care services from a Primary Care Provider whose contract is being discontinued, irrespective of whether the contract is being discontinued due to a termination for cause or without cause, or due to a non-renewal;

(2) In cases where a Health Care Provider is terminated without cause, allow a Member in an active course of treatment to continue treatment until the treatment is complete or for ninety (90) days, whichever is shorter, at the Member's In-Network Cost Share. Active course of treatment means:

(A) An ongoing course of treatment for a Life-Threatening Illness;

(B) An ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care which the Member is currently receiving, such as chemotherapy, radiation therapy, or post-operative visits;

(C) The Member has been diagnosed as being in a high-risk pregnancy or is past the twenty-fourth week of pregnancy, and shall be allowed to continue receiving covered health care services, subject to the consent of the treating health care provider, through the delivery and postpartum period related to the pregnancy and delivery; or

(D) An ongoing course of treatment for a health condition for which a treating Health Care Provider attests that discontinuing care by that Health Care Provider would worsen the condition or interfere with anticipated outcomes.

Continuity of Care is not covered by Vantage under the following conditions:

(1) The reason for such termination is due to suspension, revocation, or applicable restriction of the Health Care Provider's license to practice at such location by the applicable State Board of Medical Examiners, or for another documented reason related to quality of care.

(2) The Member chooses to change Health Care Provider.

(3) The Member moves out of the geographic service area of Vantage or a Health Care Provider.

(4) The Member requires only routine monitoring for a chronic condition but is not in an acute phase of the condition.

Any continuity of care decision made by Vantage is subject to the internal and external Grievance and Appeal processes in accordance with state or Federal law or regulations.

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 discharge a member prior to the standard length of stay. 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.

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) 998-4371 or toll-free at (844) 833-7504 for details.

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 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 conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. 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 other life-threatening disease or condition, or for the prevention or early detection of cancer or other life-threatening disease or condition; and

- The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer or other life-threatening disease or condition; 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.

Any costs related to procedures, services, research, Drugs, treatments, or supplies which are experimental or investigational in nature and certain newly introduced technologies, Drugs or other treatments are not covered.

Approved clinical trials are subject to the In-Network Cost Share, excluded from the Initial In-Network Medical Out-of-Pocket Maximum, and included in the PPACA In-Network Out-of-Pocket Maximum.

Approved clinical trials require Pre-Authorization.

SECTION V: 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. Charges in excess of the Vantage Allowable.

2. 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.

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

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

5. Losses or injuries, excluding those received by victims of domestic abuse, suffered as a result of participating in a riot, civil disturbance, illegal occupation or while committing or attempting to commit a felony or treatment of any Member convicted of a criminal offense and confined in a prison, jail, or other penal institution.

6. 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.

7. Services, equipment, 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 with Vantage and/or an Independent Review Organization (IRO), as applicable.

8. Services, surgery, supplies, treatment or expenses which are performed by or upon the direction of a Health Care Provider, Physician or allied health professional acting outside the scope of his license.

9. Any treatment or services rendered for orthodontic, periodontic, orthognathic, including temporomandibular joint (TMJ), or dental implants except as covered under the Comprehensive Dental Services benefit, the Orthodontia for Children benefit, and Cleft Lip and Cleft Palate benefits in Section IV.

10. 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.

11. Dental services not included in the FEDVIP Dental Plan in the Dental Rider.

12. Eyeglasses and contact lenses except as covered under the Glasses and Contact Lenses benefits in Section IV.

13. Replacement of damaged or lost eyeglasses and/or contact lenses.

14. Corneal surgery (except corneal transplants as specified).

15. Hearing aids, related testing and follow-up except for Newborn hearing loss screening tests and the Hearing Aid benefit for minor Members under the age of 18 in Section IV.

16. 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.

17. 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 and excluding treatments related to cleft lip and cleft palate):
    a. To change the texture or appearance of the skin (including, but not limited to, the treatment of acne);
    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;
    c. To modify the physical body in order to improve psychological, mental, or emotional well-being;
    d. To eliminate psychological stress or impairment;
    e. Treatment the sole purpose of which is to promote or stimulate hair growth;
    f. Removal of excess fat or skin, or services at a health spa or similar facility; or
    g. 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, including a contralateral prophylactic mastectomy.

18. 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 except for breast Reconstructive Services as specifically provided in this Certificate of Coverage;
    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.

    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, including a contralateral prophylactic mastectomy.

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

20. Penile implant devices and related supplies.

21. Paternity tests and tests performed for legal purposes.

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

23. 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 or parenting, and Drugs related to treatment of infertility.

24. Personal comfort and convenience items.

25. Home health services provided by Out-of-Network Providers.

26. Hospice services provided by Out-of-Network Providers.

27. Homemaker services, including but not limited to, light housekeeping or light meal preparation.

28. Home-delivered meals.

29. Any costs related to procedures, services, research, Drugs, treatments, or supplies which are experimental or investigational in nature and certain newly introduced technologies, Drugs or other treatments. 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 discretion of Vantage and/or an IRO, as applicable. 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, III, or IV clinical trials, except as covered in Section IV under the Clinical Trials benefit;
    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.

    NOTE: Members with metastatic or unresectable tumors may not be denied as a Medically Necessary Drug solely because the Drug is not indicated for the location in the body of the Member's cancer if the Drug is approved by the United States FDA for the treatment of the specific mutation of the Member's cancer. Coverage shall be included for a minimum initial treatment period of not less than 3 months and coverage shall continue after the initial treatment period if the treating Physician certifies that the Drug is Medically Necessary based on documented improvement of the Member.

30. 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.

31. Services or supplies for the treatment of eating disorders, unless otherwise required by law.

32. Food or food supplements, formulas and medical foods, including those used for gastric tube feedings. This exclusion does not apply to Low Protein Foods as described in this Plan.

33. 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;
    f. transplants otherwise excluded by this Plan; or
    g. Approved Transplant Services provided by Tier II or Out-of-Network Providers.

34. Hospitalization primarily for Physical Therapy or hydrotherapy.

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

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

37. Services, surgery, supplies, treatment, or expenses rendered by a Provider who is the Member's spouse, Child, stepchild, parent, stepparent or grandparent.

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

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

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

41. 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.

42. Services, surgery, supplies, treatment, complications from or expenses in connection with or related to sexual function, sexual dysfunctions or sexual inadequacies, regardless of claim of Medical Necessity.

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

44. Standby availability of a Health Care Provider when no treatment is rendered.

45. 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, except as required by PPACA;
    c. charges for anesthesia for non-Covered Services;
    d. over-the-counter support hose, ace or elastic bandages, and pressure garments other than those prescribed as Medically Necessary;
    e. corrective footwear;
    f. routine foot care for non-diabetic Members;
    g. wigs or hairpieces;
    h. prosthetic garments or apparel;
    i. wet nurse or milk bank services;
    j. holistic medical services;
    k. treatment of hyperhidrosis (excessive sweating);
    l. unproven methods of allergy testing (i.e., cytotoxic allergy testing);
    m. supportive devices for the foot, except when used in the treatment of diabetic foot disease; or
    n. marriage/family counseling, except as required by PPACA.

46. Gym memberships.

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

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

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

50. Fetal reduction surgery.

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

52. Out-of-country services (excluding Emergency Medical Services).

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

54. Services rendered by a micro-hospital that is not associated with a hospital.

55. 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.

56. Counseling services such as career counseling, marriage counseling, divorce counseling, parental counseling and job counseling, except as required by PPACA.

57. 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.

58. 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, not including tattoos related to breast reconstruction, and the treatment of complications from tattoos including, but not limited to, infections and Hepatitis.

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

60. 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.

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

62. Therapy received from lifestyle/habit changing clinics and/or programs, recreational programs, recreational therapy, or other therapy primarily to enhance athletic abilities, except as required by PPACA.

63. Alternative treatments, except as specifically covered, including acupressure, aromatherapy, hypnotism, massage therapy, reiki, Rolfing, yoga, and other alternative treatments defined by the Office of Alternative Medicine of the National Institutes of Health.

64. Alternative or complementary medicine using non-orthodox practices, including but not limited to wilderness or outdoor therapy, boot camp, and equine therapy.

65. Naturopath services.

66. Professional charges for clinical lab.

67. Anodyne (infrared) treatments.

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

69. The cost of health care services, treatment or testing for clinical trials except as provided for in Section IV of this Certificate.

70. Botox used for Cosmetic Purposes or for the treatment of hyperhidrosis, migraine headaches, musculoskeletal pain, fibromyalgia or other conditions not specifically listed as covered.

71. Custodial Care.

72. Outpatient private-duty nursing.

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

74. Educational testing services unrelated to the diagnosis or treatment of autism spectrum disorders, attention deficit disorders or hyperactivity.

75. Education services and supplies including training or re-training for a vocation, except as specifically provided in this Plan for diagnosis, testing, or treatment for remedial reading and learning disabilities, including dyslexia, except as required by PPACA.

76. Applied Behavior Analysis (ABA) that:
    a. Vantage has determined is not Medically Necessary;
    b. Is rendered to Members twenty-one (21) years of age and older; or
    c. Is rendered by a Health Care Provider that has not been certified as a behavior analyst by the Behavior Analyst Certification Board or rendered by a Health Care Provider that has not provided, to the satisfaction of Vantage, documented evidence of equivalent education, professional training, and supervised experience in ABA.

77. Hospital charges for a well Newborn.

78. Services or supplies for pre-implantation genetic diagnosis and pre-genetic determination.

79. Any Durable Medical Equipment, disposable medical equipment, items and supplies over reasonable quantity limits as determined by Vantage; all defibrillators other than implantable defibrillators with Pre-Authorization by Vantage.

80. Listening therapy or auditory therapy except as covered for autism spectrum disorders.

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

82. Drug screenings performed solely to ensure compliance with medical treatments, other than those performed as part of a treatment protocol.

83. Member reimbursements other than a) those submitted with itemized procedures and diagnoses documented by a Provider or b) the glasses/contacts benefits stated in Section IV.

84. Blood product injection therapies (e.g., autologous blood, platelet rich plasma, bone marrow plasma).

85. Suboxone and methadone dispensed by free standing clinics other than opioid treatment programs certified by Substance Abuse and Mental Health Services Administration (SAMHSA) for treatment for opioid dependence.

86. Sleep studies, limited to Medically Necessary home or laboratory sleep studies and associated professional claims. Only sleep studies performed in the home or sleep studies performed in a sleep laboratory that is accredited by the Joint Commission or the American Academy of Sleep Medicine (AASM) are eligible for coverage.

87. Industrial or employment-related testing or self-help programs other than PPACA preventive services including, but not limited to stress management programs, work hardening programs and/or functional capacity evaluation, including driving evaluations, etc.

88. Inpatient pain rehabilitation and pain control programs.

89. Diabetic testing supplies are limited to Glucocard Shine Meter Kit blood glucose monitoring system (1 meter per Benefit Period) and Glucocard Shine Test Strips (50-count packages) manufactured by ARKRAY USA, Inc.

90. Expenses resulting from intoxication, as defined by state law where the Illness or injury occurred, or while under the influence of illegal narcotics or controlled substances, unless administered or prescribed by a Physician.

91. For injuries sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following:
    a. Sports (professional, or semi-professional, or intercollegiate);
    b. Parachute jumping;
    c. Hang-gliding;
    d. Racing or speed testing any motorized vehicle or conveyance;
    e. Scuba/skin diving (when diving 60 or more feet in depth);
    f. Skydiving;
    g. Bungee jumping; or
    h. Rodeo sports.

92. For injuries sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following if the covered person is paid to participate or to instruct:
    a. Operating or riding on a motorcycle;
    b. Racing or speed testing any non-motorized vehicle or conveyance;
    c. Horseback riding;
    d. Rock or mountain climbing;
    e. Skiing (water or snow); or
    f. Snowboarding/ skateboarding/ kneeboarding.

93. Prescription Drug benefit exclusions and limitations:
    a. Non-Prescription Drugs, including over-the-counter (OTC) Medications with the exception of generic Zyrtec® (cetirizine), generic Claritin® (loratadine), aspirin to prevent cardiovascular disease, tobacco cessation, and others as specified by Vantage;
    b. Any Medication not proven effective in general medical practice, other than Medications used as part of a clinical trial;
    c. Medications for erectile dysfunction such as Viagra®, Cialis®, Levitra® and Caverject®;
    d. Anorexiants (weight control and obesity treatment products);
    e. Fertility agents;
    f. Lunelle® Injection or other implantable Drugs for hormone replacement therapy, pain control or any other reason, other than required PPACA contraceptive coverage; or as a part of an approved Substance Abuse program
    g. Pregnancy Termination Drugs (Abortifacients);
    h. Nutritional or dietary supplements, herbal supplements and treatments except as required by PPACA;
    i. Cosmetic Agents: Retin-A (except for acne) or other like products for Cosmetic Purposes;
    j. Minoxidil and Rogaine® or other like products for hair loss;

k. Drugs received at Out-of-Network pharmacies;
l. 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, other than Medications used as a part of a clinical trial, unless required by law;
m. Drugs used for experimental indications and/or dosage regimens determined by Vantage to be experimental, other than Medications used as a part of a clinical trial;
n. Replacement Drugs resulting from loss or theft;
o. The *additional* cost for multi-source Prescription 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;
p. Prescription Drugs related to a non-Covered Service including those written for quantities in excess of the covered benefit;
q. Selected Prescription Drugs that contain more than one (1) active ingredient (e.g. compounded Drugs);
r. Pharmacy benefits when Vantage is not the primary insurer;
s. Prescription vitamins and mineral products, prenatal vitamins and fluoride preparations, except as required by PPACA;
t. Growth hormone therapy unless an endocrinologist confirms growth hormone deficiency with an abnormal provocative stimulation test;
u. Prescription Drugs for and/or treatment of idiopathic short stature; or
v. Any Prescription Drug that is equivalent to an OTC medicine or supplement product, except as required by federal law and specified by Vantage.
w. Drugs whose principal ingredients are being mixed together for administration in a manner inconsistent with FDA approved labeling, such as, a Drug approved for oral use being administered topically or topically-applied Prescription Drug preparations approved by the FDA as medical devices, unless required by law;
x. Prescription Drug products that include or are packaged with a non-Prescription Drug product or are packaged in a way that contains multiple Prescription Drugs;
y. Prescription Drug products that contain marijuana, including medical marijuana;
z. Medication, Drugs or substances that are illegal to dispense, possess, consume or use under the laws of the United States or any state, or that are dispensed or used in an illegal manner;
aa. Coverage for Controlled Dangerous Substances that have been prescribed by multiple Providers on a concurrent basis, where a Provider agrees Prescription Drugs were obtained through Member misrepresentation to that Provider. Limitations may include requiring future Controlled Dangerous Substances to be obtained from only one (1) Provider and/or one (1) pharmacy;
bb. Prescription Drugs subject to Pre-Authorization, step therapy and/or quantity limits that were not approved by Vantage;
cc. Prescription Drugs approved for self-administration (for example, oral or self-injectable drugs) are not covered when obtained from an Out-of-Network Provider; and
dd. Covered antihemophilic drugs, immune globulins, drugs recommended by the Food and Drug Administration (FDA) prescribing information to be administered by a healthcare professional, or drugs whose routes of administration include intravenous bolus and infusion, intramuscular, implantable, intrathecal, intraperitoneal, intrauterine, pellets, pumps, and other routes of administration that are covered under the medical benefit and not covered under the Prescription Drug benefit, unless required by law;.

SECTION VI: ELIGIBILITY FOR COVERAGE

Eligibility requirements in the OGB Benefit Plan apply to all participants in OGB-sponsored health plans and the OGB life insurance plan.

THE PLAN ADMINISTRATOR HAS FULL DISCRETIONARY AUTHORITY TO DETERMINE ELIGIBILITY FOR COVERAGE/BENEFITS AND/OR TO CONSTRUE THE TERMS OF THIS PLAN.

NOTE: A Temporary Employee does not meet the Eligibility Requirements under this Benefit Plan, unless such Temporary Employee is determined to be a FTE.

A. Persons to be Covered

1. Employee

   a. A full-time Employee as defined by a Participant Employer and any FTE, both as determined in accordance with applicable state and federal law.

   b. Spouse, 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 is eligible for coverage as an Employee and chooses to be covered separately at a later date, 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.

   c. Effective Dates of Coverage, New Employee, Transferring Employee, and FTE

      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:

      (1) For new full-time Employees, 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 1st, coverage will begin on August 1st).

      (2) For new full-time Employees, 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 15th, coverage will begin on September 1st).

      (3) Employee coverage will not become effective unless the Employee completes an enrollment form within thirty (30) days following the date of employment. If the Employee does not timely complete an enrollment form, the Employee will have to wait to enroll until the next Annual Enrollment period or Special Enrollment period.

      (4) An Employee who transfers employment to another Participant Employer must complete a transfer form within thirty (30) days following the date of transfer to maintain coverage without interruption. If the Employee does not timely complete an enrollment form, the Employee will have to wait to enroll until the next Annual Enrollment period or Special Enrollment period.

      (5) An Employee who is determined to be a FTE will be allowed to enroll in the Plan with coverage effective as required under Code Section 4980H, which is the first day of the Plan Year for those Employees determined to be FTEs during the standard determination period and which is no later than the thirteenth month of employment for those Employees determined to be FTEs during their initial measurement period.

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

(1) Full-time Employees returning to full time or part-time status with less than thirteen (13) weeks (less than 26 weeks for educational institutions) since separation or termination may resume coverage if application is made within thirty (30) days following return to work. Coverage will resume on the first of the month following return to work.

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

e. Board and Commission Members

Except as otherwise provided by law, board and commission members are not eligible to participate in this 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.

f. Legislative Assistants

A legislative assistant is eligible to participate in the Plan if he or she is determined to be a full-time Employee by the Participant Employer under applicable federal and state law or pursuant to La. R.S. 24:31.5(C), and either:

- Receives at least sixty (60) percent of the total compensation available to employ the legislative assistant if the legislator Employer employs only one legislative assistant; or
- Is the primary legislative assistant as defined in La. R.S. 24:31.5(C) when a legislator Employer employs more than one legislative assistant.

2. Retiree Coverage - Eligibility

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

b. Retirees of Participant Employers may not be covered as an Employee.

c. Effective Date of Coverage - Retiree coverage will be effective on the first day of the month following the date of retirement, if the Retiree and Participant Employer have agreed to make and are making the required contributions. For purposes of eligibility, the date of retirement shall be the date the person is eligible to receive a retirement plan distribution. For example, if date of retirement is July 15, retiree coverage will begin August 1; if date of retirement is August 1, retiree coverage will begin September 1.

3. Documented Dependent Coverage - Eligibility

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

(1) The date the Employee becomes eligible;

(2) The date the Retiree becomes eligible; or

(3) The Date Acquired for Employee's/Retiree's Dependents.

b. Effective Dates of Coverage – Application for coverage must be made within thirty (30) days of eligibility for coverage.

(1) Documented Dependents of Employees - Coverage will be effective on the Date Acquired.

(2) Documented Dependents of Retirees - Coverage will be effective on the first day of the month following the date of retirement if the Retiree 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 Acquired.

c. 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.

4. Special Enrollment Period

Certain eligible persons may enroll by written application as provided by HIPAA under the following circumstances, terms, and conditions for special enrollments:

a. 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:

(1) Loss of eligibility through legal separation, divorce, annulment, termination of employment, reduction in hours, or death of the Spouse;

(2) Cessation of Participant Employer contributions for the other coverage, unless the Participant Employer's contributions were ceased for cause or for failure of the Employee or Dependent (as applicable) to make contributions;

(3) 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; or

(4) Loss of eligibility due to termination of Medicaid or State Children's Health Insurance Program (SCHIP) coverage.

b. Eligibility for Premium assistance subsidy under Medicaid or SCHIP.

c. A special enrollment application must be made within thirty (30) days of either the termination date of the prior coverage or the Date Acquired for new Dependents or within sixty (60) days of the events identified in 4.a.(4) and 4.b. above.

5. Medicare Advantage Option for Retirees other than OGB sponsored plans

Retirees who are eligible to participate in a Medicare Advantage plan who cancel coverage with the Plan upon enrollment in such Medicare Advantage plan may re-enroll in the Plan upon withdrawal from or termination of coverage in the Medicare Advantage plan during the next Annual Enrollment, for coverage effective at the beginning of the next Plan Year.

Retirees who elect to participate in a Medicare Advantage Plan not sponsored by OGB will not be allowed to reenroll in a plan offered by OGB upon withdrawal from or termination of coverage in the Medicare Advantage Plan.

6. 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 Plan upon enrollment in TFL may re-enroll in the Plan in the event that the TFL option is discontinued or its Benefits significantly reduced.

B. Continued Coverage

1. Leave of Absence

a. Leave of Absence without Pay, Employer Contributions to Premiums

(1) A participating Employee who is granted leave of absence without pay due to a service related injury may continue coverage and the Participant Employer shall continue to pay its portion of health plan Premiums for up to twelve (12) months if the Employee continues his/her coverage. Failure of the Employee to pay the Premium will result in cancellation of coverage.

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

(3) A participating Employee who is granted leave of absence without pay in accordance with the federal Family and Medical Leave Act (FMLA) may continue coverage during the time of such leave and the Participant Employer shall continue to pay its portion of Premiums if the Employee continues his/her coverage. Failure of the Employee to pay the Premium will result in cancellation of coverage.

b. Leave of Absence Without Pay - No Employer Contributions to Premiums

An Employee granted leave of absence without pay for reasons other than those stated above in B.1., may continue to participate in an OGB Plan for a period up to twelve (12) months upon the Employee's payment of the full Premiums due.

THE PARTICIPANT EMPLOYER AND THE EMPLOYEE MUST NOTIFY THE PLAN ADMINISTRATOR WITHIN THIRTY (30) DAYS OF THE EFFECTIVE DATE OF THE LEAVE OF ABSENCE.

2. Disability

a. 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.

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

3. Surviving Dependents/Spouse

a. 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.

(1) 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.

(2) The surviving Dependent Child of an Employee or Retiree may continue coverage unless or until such Dependent Child is or becomes eligible for coverage under a group health plan other than Medicare or until end of the month of the attainment of the termination age for that specific Dependent Child, whichever occurs first.

(3) 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.

(4) 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.

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

c. Participant Employer/Dependent Responsibilities

(1) It is the responsibility of the Participant Employer and surviving covered Dependent to notify the Plan Administrator within thirty (30) days of the death of the Employee or Retiree.

(2) The Plan Administrator will notify the surviving Dependents of their right to continue coverage.

(3) Application for continued coverage must be made in writing to the Plan Administrator within sixty (60) days of receipt of notification, and Premium Payment must be made within forty-five (45) days of the date continued coverage is elected for coverage retroactive to the date coverage would have otherwise terminated.

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

(a) Failure to pay the applicable Premium timely; or

(b) Eligibility of the surviving Spouse under a group health plan other than Medicare.

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

(a) Failure to pay the applicable Premium timely;

(b) Eligibility of the surviving Dependent child for coverage under any group health plan other than Medicare; or

(c) The end of the month of attainment of the termination age for that specific Dependent Child.

d. The provisions of 3.a through 3.c. above 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 that made such election before July 1, 1999, shall be governed by the rules in effect at the time of the election.

4. Over-Age Dependents

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

a. Prior to the Dependent Child reaching age twenty-six (26), an application for continued coverage, with current medical information from the Dependent Child's attending Physician, along with the Child's attending Physician's attestation of the Child's incapacity to perform self-sustaining employment, must be submitted to the Plan Administrator to establish eligibility for continued coverage as set forth above.
b. Upon receipt of the application for continued coverage and Physician's attestation, the Plan Administrator may require additional medical documentation regarding the Dependent Child's incapacity as often as it may deem necessary as a precondition to continue coverage.

5. Military Leave

Employees in the National Guard or in the United States military reserves who are called to active military duty and their covered eligible Dependents will have access to continued coverage under OGB's health and life plans subject to submittal of appropriate documentation to OGB.

a. Health Plan Participation - When an Employee is called to active military duty, the Employee and his/her covered eligible Dependents may:

(1) continue participation in the health plan during the period of active military service, in which case the Participant Employer may continue to pay its portion of Premiums; or

(2) cancel participation in the health plan during the period of active military service, in which case the Employee may apply for reinstatement of OGB coverage within thirty (30) days of:

(i) the date of the Employee's re-employment with a Participant Employer; or

(ii) the date of termination of extended health coverage provided as a benefit of active military duty, such as TRICARE Reserve Select. For Employees who elect this option and timely apply for reinstatement of OGB coverage, 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.

C. COBRA

1. Employees

a. 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.

b. It is the responsibility of the Participant Employer to notify the Plan Administrator within thirty (30) days of the date coverage would have terminated because of any of the foregoing events. OGB's third-party COBRA vendor ("COBRA Administrator") will notify the Employee within fourteen (14) days of his right to continue coverage.

c. Application for continued coverage must be made in writing to the COBRA Administrator within sixty (60) days of the date of the election notification, and Premium Payment must be made to the COBRA Administrator within forty-five (45) days of the date the Employee elects continued coverage. Coverage will be retroactive to the date it would have otherwise terminated.

d. Coverage under this section will continue until the earliest of the following:

(1) Failure to pay the applicable Premium timely;

(2) Eighteen (18) months from the date coverage would have otherwise terminated;

(3) Entitlement to Medicare;

(4) Coverage under a group health plan; or

(5) The Employer ceases to provide any group health plan for its Employees/Retirees.

e. If employment for a covered Employee is terminated (voluntarily or involuntarily) or significantly reduced, the Employee no longer meets the definition of an Employee, or Leave of Absence has expired, and the Employee has not elected to continue coverage, the covered Spouse and/or covered Dependent Children may elect to continue coverage at his own expense. The elected coverage will be subject to the above stated notification and termination provisions.

2. Surviving Dependents

a. Coverage under this Plan for covered surviving Dependents of an Employee/Retiree will terminate on the last day of the month in which the Employee's/Retirees death occurs, unless the surviving covered Dependents elect to continue coverage at their own expense.

b. It is the responsibility of the Participant Employer or surviving covered Dependents to notify the Plan Administrator within thirty (30) days of the death of the Employee/Retiree. The COBRA Administrator will notify the surviving Dependents of their right to continue coverage. Application for continued

coverage must be made in writing to the COBRA Administrator within sixty (60) days of the date of the election notification.

c. Premium Payment must be made to the COBRA Administrator within forty-five (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 thirty (30) days after the first day of the month will be provided for each monthly payment.

d. Coverage for the surviving Dependents under this section will continue until the earliest of the following:

(1) Failure to pay the applicable Premium timely;

(2) Thirty-six (36) months beyond the date coverage would have otherwise terminated;

(3) Entitlement to Medicare;

(4) Coverage under a group health plan; or

(5) The Employer ceases to provide any group health plan for its Employees/Retirees.

3. Ex-Spouse/Ex-Stepchildren – Divorce, Annulment or Legal Separation

a. Coverage under this Plan for an Employee's/Retiree's Spouse (and any stepchildren enrolled on the Plan) will terminate on the last day of the month during which dissolution of the marriage occurs by virtue of a legal decree of divorce, annulment, or legal separation from the Employee/Retiree, unless the covered ex-Spouse elects to continue coverage at his/her own expense.

b. It is the responsibility of the Employee/Retiree to notify the Plan Administrator of the divorce, annulment, or legal separation within sixty (60) days from the date of the divorce, annulment, or legal separation. The COBRA Administrator will notify the ex-Spouse (and any ex-stepchildren of the Employee/Retiree who were enrolled on the Plan) within fourteen (14) days of his/her/their right to continue coverage. Application for continued coverage must be made in writing to the COBRA Administrator within sixty (60) days of the election notification.

c. Premium Payment must be made to the COBRA Administrator within forty-five (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 thirty (30) days after the first day of the month will be provided for each monthly payment.

d. Coverage for the ex-Spouse (and any ex-stepchildren of the Employee/Retiree who were enrolled on the Plan) under this section will continue until the earliest of the following:

(1) Failure to pay the applicable Premium timely;

(2) Thirty-six (36) months beyond the date coverage would have otherwise terminated;

(3) Entitlement to Medicare;

(4) Coverage under a group health plan; or

(5) The Employer ceases to provide any group health plan for its Employees/Retirees.

4. Dependent Children

a. Coverage under this Plan for a covered Dependent Child 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 Child elects to continue coverage at his own expense.

b. It is the responsibility of the Dependent Child to notify the Plan Administrator of his loss of eligibility within sixty (60) days of the date coverage would have terminated. The COBRA Administrator will notify the Dependent Child within fourteen (14) days of his/her right to continue coverage. Application for continued coverage must be made in writing to the COBRA Administrator within sixty (60) days of receipt of the election notification.

c. Premium Payment must be made to the COBRA Administrator within forty-five (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 thirty (30) days after the first day of the month will be provided for each monthly payment.

d. Coverage for a Dependent Child under this section will continue until the earliest of the following:

(1) Failure to pay the applicable Premium timely;

(2) Thirty-six (36) months beyond the date coverage would have otherwise terminated;

(3) Entitlement to Medicare;

(4) Coverage under a group health plan; or

(5) The Employer ceases to provide any group health plan for its Employees/Retirees.

5. Dependents of COBRA Participants

a. If a covered terminated Employee has elected to continue coverage and if during the period of continued coverage the covered Spouse or a covered Dependent Child becomes ineligible for coverage due to:

(1) Death of the Employee,

(2) Divorce, Annulment, or Legal Separation from the Employee, or

(3) 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/her own expense. Coverage will not be continued beyond thirty-six (36) months from the date coverage would have otherwise terminated.

b. It is the responsibility of the Spouse and/or the Dependent Child to notify the Plan Administrator within sixty (60) days of the date COBRA coverage would have terminated.

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

d. Coverage for the Spouse or Dependent Child under this section will continue until the earliest of the following:

(1) Failure to pay the applicable Premium timely;

(2) Thirty-six (36) months beyond the date coverage would have otherwise terminated;

(3) Entitlement to Medicare;

(4) Coverage under a group health plan; or

(5) The Employer ceases to provide any group health plan for its Employees/Retirees.

6. Disability COBRA

a. If a Plan Participant is determined by the Social Security Administration or by the COBRA Administrator 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 Plan Participant became eligible for continued coverage or within the initial eighteen (18) months of continued coverage, coverage under this Plan may be extended at his own expense up to a maximum of twenty-nine (29) months from the date coverage would have otherwise terminated.

b. To qualify for disability COBRA, the Plan Participant must:

(1) Submit a copy of his/her Social Security Administration's disability determination to the COBRA Administrator before the initial eighteen (18) month continued coverage period expires and within sixty (60) days after the latest of:

(a) The date of issuance of the Social Security Administration's disability determination; and

(b) 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.

(2) 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 COBRA Administrator before the initial eighteen (18) month continued coverage period expires. The staff and medical director of the COBRA Administrator 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.

c. For purposes of eligibility for extended 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 twelve (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.

d. Monthly payments for each month of extended disability COBRA coverage are due to the COBRA Administrator on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

e. Coverage under this section will continue until the earliest of the following:

(1) Failure to pay the applicable Premium timely;

(2) Twenty-nine (29) months from the date coverage would have otherwise terminated;

(3) Entitlement to Medicare;

(4) Coverage under a group health plan;

(5) The Employer ceases to provide any group health plan for its Employees/Retirees; or

(6) Thirty (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 Plan Administrator and the COBRA Administrator within thirty (30) days after the date of issuance by the Social Security Administration.) In the case of a person who is ineligible for Social Security disability benefits due to insufficient quarters of an employment, thirty (30) days after the month in which the COBRA Administrator determines that the Covered Person is no longer disabled.

7. Medicare COBRA

a. If an Employee becomes entitled to Medicare less than eighteen (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:

(1) Failure to pay the applicable Premium timely;

(2) Thirty-six (36) months from the date of the Employee's Medicare entitlement;

(3) Entitlement to Medicare;

(4) Coverage under a group health plan; or

(5) The Employer ceases to provide any group health plan for its Employees/Retirees.

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

8. Miscellaneous Provisions

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

D. Change of Classification

1. Adding or Deleting Dependents

When a Dependent is added to the Employee's/Retiree's coverage as a result of a HIPAA Special Enrollment Event or deleted from the Employee's/Retiree's coverage consistent with a change in the Dependent's status, application made by an active Employee shall be provided to the Employee's Human Resources liaison, and application made by a Retiree shall be provided to OGB. Application is required to be made within thirty (30) days of the HIPAA Special Enrollment Event or change in status unless otherwise specified in this Plan document or unless a longer application period is required by federal or state law. When a Dependent is added to or deleted from coverage during an OGB-designated enrollment period, application is required to be made as directed by OGB for the designated enrollment period.

2. Change in Coverage

When the addition of a Dependent as a result of a HIPAA Special Enrollment Event results in a change in classification, the change in classification will be effective on the date of the HIPAA Special Enrollment Event.

3. Notification of Change

It is the Employee's/Retiree's responsibility to make application for any change in classification of coverage.

E. Contributions

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

F. Medical Child Support Orders

A Dependent Child shall be enrolled for coverage under the Plan in accordance with the direction of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN). An Employee who is not currently enrolled in an OGB Plan may enroll to effect coverage for his or her Dependent(s) who are the subject of the QMCSO.

A QMCSO is a state court order or judgment, including approval of a settlement agreement that:

1. Provides for support of a covered Plan Participant's Dependent Child;
2. Provides for health care coverage for that Dependent Child;
3. Is made under state domestic relations law (including a community property law);
4. Relates to Benefits under the Plan; and
5. Is "qualified" in that it meets the technical requirements of applicable state law.

QMCSO also means a state court order or judgment that enforces a state Medicaid law regarding medical child support required by Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993).
An NMSN is a notice issued by an appropriate agency of a state or local government that is similar to a QMCSO that requires coverage under the Plan for the Dependent Child of a non-custodial parent who is (or will become) a Covered Person by a domestic relations order that provides for health care coverage.

SECTION VII: 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. Whenever Vantage does not receive a Premium Payment fifteen (15) days prior to the end of the grace period, Vantage shall mail, by first class mail, a notice to the Subscriber. The notice shall state that if the Premium has not been paid by the end of the grace period, the Plan will lapse as provided by the provisions of the policy. 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, and the Plan is reinstated. 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;

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;

3. the date the Program terminates or the date the Participant Employer employing the Employee terminates or withdraws from the Program;

4. the date Vantage determines the Employee is ineligible due to intentional material misrepresentation and/or noncompliance with Vantage procedures or breaches any provision of this Plan; or

5. 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;

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;

3. the date the Program terminates or the date the Participant Employer employing the Employee terminates or withdraws from the Program;

4. the date Vantage determines the Dependent is ineligible due to intentional material misrepresentation and/or noncompliance with Vantage procedures or breaches any provision of this Plan;

5. the last day of the month of the Dependent's death; or

6. for Dependent Grandchildren for whom the Employee does not have legal custody, whose parent is covered under the Plan as a Dependent, or a child for whom the Employee/Retiree has current provisional custody, which grandchild/child has not been adopted by the Employee/Retiree and for whom the Employee/Retiree has not obtained court-order legal guardianship/tutorship or court-ordered custody, provided the grandchild/child was enrolled as a Plan Participant and met the eligibility requirements of a "Child" as of December 31, 2015; until end of month the parent Dependent Child is no longer enrolled on or eligible to participate in the Plan, the end of the month the grandchild or dependent of a dependent turns twenty-six (26), or the grandchild or dependent of a dependent no longer meets the eligibility requirements under this Plan, whichever is earlier.

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

Vantage may choose to rescind coverage or terminate a Member's coverage if a Member performs an act or practice that constitutes fraud, or makes an intentional misrepresentation of material fact under the terms of this Plan. The issuance of this coverage is conditioned on the representations and statements contained at application and enrollment. All representations made are material to the issuance of this Plan. Any information provided on the application or enrollment form or intentionally omitted therefrom, as to any proposed Subscriber or covered Member, shall constitute an intentional misrepresentation of material fact. A Member's coverage may be rescinded retroactively to the effective date or terminated within three (3) years of the Member's effective date, for fraud or intentional misrepresentation of material fact. Vantage will give the Member thirty (30) days advance written notice prior to rescinding or terminating coverage under this section.

SECTION VIII: CLAIMS PROVISIONS

A. **Proof of Services**

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. Failure to furnish such proof within 90 days of the date the charge was incurred shall not invalidate nor reduce any claim if, it was not reasonably possible for the member to give proof within such time. However, in such cases, proof must be furnished as soon as reasonably possible and in no event can a member provide proof later than one year and ninety days (90) after the charge was incurred. Written proof for medical claims must consist of procedures and diagnoses itemized by the Provider on a claim form (CMS-1450 or CMS-1500) or a superbill along with documentation of any payments you have made. Written proof for Prescription Drug claims must consist of a Prescription Drug receipt from the Pharmacy and proof of payment. 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 the Member receives the explanation of benefits from the primary carrier.

Mail your request for payment together with the written proof for claims to Vantage at the address below. It is a good idea to make a copy of this documentation for your records.

Vantage Health Plan, Inc.
Attn: Member Services Department
130 DeSiard Street, Suite 300
Monroe, LA 71201

Contact Member Services at (318) 998-4371 or toll-free at (844) 833-7504 if you have any questions or if you want to give us more information about a request for payment you have already sent to Vantage.

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 shall not retroactively deny, adjust, or seek recoupment or refund of a paid claim for healthcare expenses submitted by a healthcare provider for healthcare services rendered in good faith and pursuant to the Benefit Plan after the expiration of eighteen (18) months from the date the initial claim was paid.

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 and/or drugs are itemized a) by the Provider on a claim form (CMS-1450 or CMS-1500) or a superbill, or b) on a Prescription Drug receipt from the Pharmacy submitted to Vantage.

Payment of claims for Emergency Medical Services provided by Out-of-Network Health Care Providers A. If a Health Care Provider that does not contract with a Plan files a claim with a Plan for Emergency Medical Services rendered, the Plan shall directly pay such a claim by a Out-of-Network Health Care Provider in the amount as determined pursuant to the Plan or policy provisions between the Member and Plan, less any amount representing Co-insurance, Co-payments, Deductibles, non-Covered Services, or any other amounts identified by the Plan pursuant to the plan or policy provisions, as an amount for which the Member is liable. Payment of such claim by the Plan shall in no circumstances be made directly to the patient or Member.

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 individuals: Member's legal representative, his/her spouse or parent(s) or Child(ren) or brother(s) or sister(s), or 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.

The Member may NOT assign benefits to Providers. However, the Member understands that Participating Providers reserve the ability to directly pursue any third parties who cause accidental injury or Illness to the Members for the full amount of the cost of the medical services rendered to the 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 services 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 services 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 services is required to be furnished, or prior to completion by the Member of the Appeal and Grievance Procedures under this Plan.

SECTION IX: COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when a Member has health care coverage under more than one Plan. Plan is defined below. The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense as provided for in §303A.(a.-e.) of Regulation 32.

DEFINITIONS
For purposes of this section, the following definitions apply:

A. A *Plan* is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) Plan includes: group and nongroup insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage except those enumerated in LSA-R.S. 22:1000 A.3C; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether this Plan is a Primary plan or Secondary plan when the Member has health care coverage under more than one Plan. When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

D. *Allowable expense* is a health care service or expense, including deductibles, coinsurance and copayments, that is covered in full or at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense or service that is not covered by any Plan covering the person is not an Allowable expense. The following are examples of expenses that are and are not an Allowable expenses:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

(2) If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

(3) If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

(4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans.

(5) The amount of any benefit reduction by the Primary plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. *Closed panel plan* is a Plan that provides health care benefits to Members primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. *Custodial parent* is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

G. *High-Deductible Health Plan* - the meaning given the term under section 223 of the Internal Revenue Code of 1986, as amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

ORDER OF BENEFIT DETERMINATION RULES

When a Member is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

(1) Except as provided in Paragraph (2), a Plan that does not contain a Coordination of Benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

B. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

C. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
   i. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
   ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

b. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
   i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
   ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
   iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
   iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
      (a) The Plan covering the Custodial parent;
      (b) The Plan covering the spouse of the Custodial parent;
      (c) The Plan covering the non-custodial parent; and then
      (d) The Plan covering the spouse of the non-custodial parent.

c. For a dependent child covered under more than one Plan of individuals who are the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

d. For a dependent child covered under spouse's plan
   i. For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in Paragraph (5) applies.
   ii. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in Subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

(3) Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would

hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible, coinsurance, copayments and any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

C. Effect on the Benefits of This Plan

1. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year or claim determination period are not more than 100 percent of total allowable expenses. The difference between the benefit payments that this plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided shall be recorded as a benefits reserve for the covered person and used by this plan to pay any allowable expenses, not otherwise paid during the claim determination period. As each claim is submitted, this plan will:
    a. determine its obligation to pay or provide benefits under its contract;
    b. determine whether a benefit reserve has been recorded for the covered person; and
    c. determine whether there are any unpaid allowable expenses during that claims determination period.

2. If there is a benefit reserve, the secondary plan will use the covered person's benefit reserve to pay up to 100 percent of total allowable expenses incurred during the claim determination period. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

3. If a covered person is enrolled in two or more closed panel plans, and if for any reason, including the provision of service by a nonpanel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

This is a summary of only a few of the provisions of your health plan to help you understand coordination of benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace any language, which determines your benefits.

Double Coverage
It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.
When you are covered by more than one health plan, state law permits your insurers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Coordination of Benefits (COB) is complicated and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, read your evidence of coverage or contact your state insurance department.

Primary or Secondary?
You will be asked to identify all the plans that cover members of your family. We need this information to determine whether we are the "primary" or "secondary" benefit payer. The primary plan always pays first when you have a claim.

Any plan that does not contain your state's COB rules will always be primary.

When This Plan is Primary
If you or a family member are covered under another plan in addition to this one, we will be primary when:

Your Own Expenses
- The claim is for your own health care expenses, unless you are covered by Medicare and both you and your spouse are retired.

Your Spouse's Expenses
- The claim is for your spouse, who is covered by Medicare, and you are not both retired.

Your Child's Expenses
- The claim is for the health care expenses of your child who is covered by this plan and
- You are married and your birthday is earlier in the year than your spouse's or you are living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier that that other individual's birthday. This is known as the "birthday rule"; or
- You are separated or divorced and you have informed us of a court decree that makes you responsible for the child's health care expenses; or
- There is no court decree, but you have custody of the child.

Other Situations
We will be primary when any other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary
When we are the primary plan, we will pay the benefits in accordance with the terms of your contract, just as if you had no other health care coverage under any other plan.

When is Vantage Secondary
We will be secondary whenever the rules do not require us to be primary.

How We Pay Claims When We Are Secondary
When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay part or all of the allowable expenses left unpaid, as explained below. An "allowable expense" is a health care service or expense covered by one of the plans, including copayments, coinsurance and deductibles.

- If there is a difference between the amount the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the provider, our combined payments will not be more than the contract calls for. Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) usually have contracts with their providers.
- We will determine our payment by subtracting the amount the primary plan paid from the amount we would have paid if we had been primary. We will use any savings to pay the balance of any unpaid allowable expenses covered by either plan.
- If the primary plan covers similar kinds of health care expenses, but allows expenses that we do not cover, we will pay for those items as long as there is a balance in your benefit reserve, as explained below.
- We will not pay an amount the primary plan did not cover because you did not follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain pre-certification, as required by that plan, we will not pay the amount of the reduction, because it is not an allowable expense.

Benefit Reserve

- When we are secondary we often will pay less than we would have paid if we had been primary. Each time we "save" by paying less, we will put that savings into a benefit reserve. Each family member covered by this plan has a separate benefit reserve. We use the benefit reserve to pay allowable expenses that are covered only partially by both plans. To obtain a reimbursement, you must show us what the primary plan has paid so we can calculate the savings. To make sure you receive the full benefit or coordination, you should submit all claims to each of your plans. Savings can build up in your reserve for one year. At the end of the year any balance is erased, and a fresh benefit reserve begins for each person the next year as soon as there are savings on their claims.

Questions about Coordination of Benefits?
Contact Your State Insurance Department.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION
Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. Vantage may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the person claiming benefits. Vantage need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give Vantage any facts it needs to apply those rules and determine benefits payable.

Please see the Coordination of Benefits Notice located at Appendix C- Explanation for Secondary Plans on the Purpose and Use of the Benefit Reserve on the LDI website under the following link: *http://www.ldi.la.gov/consumers/resources-publications/consumer-publications*. You may also request that a Coordination of Benefits Notice be mailed to you by contacting Member Services at (844) 833-7504.

FACILITY OF PAYMENT
A payment made under another Plan may include an amount that should have been paid under This plan. If it does, Vantage may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This plan. Vantage will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY
If the amount of the payments made by Vantage is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

SECTION X: SUBROGATION

Recovery of the Cost of Benefits
If a Member is injured or becomes ill through the act of another person 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 legally responsible for such payment. To the extent that benefits are provided under this Plan, Vantage shall be subrogated to all rights of recovery which a Member may acquire against any other party for the recovery of the amount paid under this Plan. To the extent Vantage is required by state and/or federal law to ensure that a member is fully compensated before exercising its recovery rights, then Vantage will comply with such laws. In the absence of full compensation laws being applicable or in the event federal law preempts state law, Vantage's right to recovery will not be secondary to a member's compensation. At Vantage's request, the Member shall provide the information needed (as determined by Vantage) to secure and protect Vantage's subrogation rights. The Member also has an obligation to execute and deliver any documentation Vantage deems necessary to secure and protect its subrogation rights. The Member further agrees to cooperate with Vantage and/or representatives of Vantage, including its attorneys, in completing any 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. Vantage agrees to pay its portion of the Member's attorney's fees or other costs associated with a claim or lawsuit to the extent Vantage recovers any portion of the benefits paid under this Plan pursuant to Vantage's right of subrogation. 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. If the Member is in an automobile accident, he/she should contact Vantage within five (5) business days to coordinate the payment of the Member's claims. Vantage shall pay claims related to the Member's injury and shall be reimbursed by any and all available insurance policies covering the responsible party (ies).
- To seek recovery from the responsible person or entity (or his/her/its insurer) of all amounts in connection with benefits paid by Vantage under this Plan and to notify Vantage within five (5) business days of any such actions taken by the Member.
- To refrain from any action or inaction which would delay, impair, prejudice, discharge or otherwise compromise Vantage's rights of subrogation, which would include, but not be limited to accepting any settlement offer from any responsible person or entity (or his/her/its insurer) without the prior written consent of Vantage.
- 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 representatives, agents, and attorneys.
- To notify Vantage of and pay to Vantage any amounts received by the Member or Member's legal representatives, agents, or attorneys 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 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 and protecting 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 or Member's representatives, agents or attorneys 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
If they have obtained written consent of the member, 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 only 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 the Member shall cooperate in providing this information to Participating Providers. Participating Providers who elect to pursue third parties for a recovery shall not, under any circumstances, submit their claims to Vantage for payment, but may only pursue the third parties for recovery. In such an event, and if full recovery is not made by the Participating Providers, the 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. If the Participating Provider did not obtain written consent from the Member to seek recovery from third parties, then Participating Provider may not bill the Member for any amounts that were 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 homeowner's insurance coverage including premises or homeowner's 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 Vantage is legally required by state law to apply full compensation rules, and such rules are 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. In connection therewith, the Member has the obligation of establishing whether he/she has been made whole. 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 specifically, the provisions of this Section X, the Member shall reimburse Vantage for any and all costs and expenses including attorney fees incurred by Vantage in enforcing its rights hereunder. 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. 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. It is specifically recognized that this Plan and the rights of Vantage and its Members are governed by ERISA, unless otherwise exempted.

The Member acknowledges and agrees that the use of this policy of health insurance is subject to the terms and conditions set forth in the policy's Certificate of Coverage including, but not limited to, Vantage's right to subrogation.

SECTION XI: APPEAL & GRIEVANCE PROCEDURES

Vantage recognizes its responsibility to provide Members with adequate methods to make inquiries and express concerns regarding Vantage or a Health Care Provider. Members are encouraged to contact Vantage's Member Service department for assistance with complaints or suggestions concerning the Plan.

As a Member of this Plan, you have the right to file a complaint if you have concerns related to:

(a) Availability, delivery, or quality of health care services, including a complaint regarding an Adverse Determination made by Vantage's Utilization Review procedures;
(b) Claims payment, handling, or reimbursement for health care services; or
(c) Matters pertaining to your contract with Vantage.

Members also have the right to notices of the decisions rendered on claims and Appeals to be provided in a culturally and linguistically appropriate manner, of available internal and external Appeals processes and the availability of the Louisiana Department of Insurance to assist with the Appeals process. You have the right, upon request and free of charge, to review and have copies of all documents relevant to the claim for benefits and to submit comments and documents relating to the claim, without regard to whether that information was submitted or considered in the initial benefit determination, and to receive continued coverage pending the outcome of the Appeals process where required by applicable law of the Plan.

Vantage considers a **Grievance** to be the type of complaint you file if you have any *concerns* related to the quality of care or services received from Vantage or a Health Care Provider. *Examples of a Grievance*:

(a) Unpleasant attitudes or behavior at a Health Care Provider;
(b) Lengthy wait times in a Health Care Provider's facility;
(c) Difficulty scheduling an appointment or contacting a Health Care Provider;
(d) Complaints that a procedure or item during a course of treatment did not meet accepted standards for delivery of health care; or
(e) Concerns or difficulty when contacting Vantage or communicating with a Vantage Employee.

To file a Grievance, you may call Vantage's Member Services department Monday through Friday from 8:00 a.m. to 6:00 p.m. by calling (318) 998-4371 or toll-free at (844) 833-7504. A Member Services Representative will attempt to resolve the Grievance at the time of the call.

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

An **Appeal** is the type of complaint you file when you want Vantage to reconsider an *Adverse Determination* made by Vantage.

Examples of an Appeal:

(a) A determination that a request for a benefit does not meet Vantage's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit.
(b) Vantage's denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit due to your eligibility to participate in our Plan.
(c) Any pre-service or post-service review where Vantage denies, reduces, or terminates or fails to provide or make payment, in whole or in part for a benefit.
(d) A Rescission of coverage determination, meaning if Vantage cancels or discontinues coverage after services have already been provided, except for circumstances when coverage is terminated due to a failure to timely pay your required Premiums or contributions towards the cost of coverage.

OGB Eligibility Appeal Process

OGB retains the authority to make all determinations regarding eligibility, except for rescissions of coverage determinations and those determinations involving medical judgment regarding the incapacity of over-age Dependents. All eligibility appeals except for rescissions of coverage determinations and those determinations involving medical judgment regarding the incapacity of over-age Dependents must be submitted within 180 calendar days following the denial of coverage to State of Louisiana Office of Group Benefits, Post Office Box 44036, Baton Rouge, Louisiana 70804 (rather than to Vantage), and OGB shall have sixty (60), rather than thirty (30) calendar days, in which to respond to the appeal. Rescissions of coverage determinations and those determinations regarding the incapacity of over-age Dependents shall be subject to the procedures set forth below.

APPEAL AND GRIEVANCE PROCEDURES

Any Member that wishes to file an Appeal or Grievance should call Vantage's Member Service department. Member Services is available Monday through Friday from 8:00 a.m. to 6:00 p.m. by calling (318) 998-4371 or toll-free at (844) 833-7504.

The Vantage Member Services Representative will review the situation and can often resolve the complaint during the call. If the Member's complaint is resolved, a report of the communication, description of the findings, and the resolution or actions taken will be placed in the Member's file.

If the Member Services Representative is unable to resolve the complaint to the Member's satisfaction, the Member may file a formal Appeal or Grievance.

First Level Internal Review

Members may file a formal Appeal or Grievance for further review of a complaint. A formal Appeal or Grievance must be submitted within **one hundred eighty (180) days** from the date of the initial decision. Written requests for review can be faxed, mailed or hand-delivered to:

Vantage Health Plan, Inc.
Attn: Appeals and Grievances
130 DeSiard Street, Suite 300
Monroe, LA 71201
Grievance Fax: 318-361-2159
Standard Appeal Fax: 318-361-2181
Expedited Request Fax: 318-361-2170

Please include the following:

- Member's name, address and Member identification number
- A summary of the reason for the review
- A description of the solution desired by the Member
- Signature of the Member or Authorized Representative

The letter 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 letter and information related to the complaint. If any evidence generated by Vantage is utilized in connection with the review to which the Member does not have access, Vantage will, if needed, make that information available to the Member and allow Members, upon request and free of charge, to review and have copies of all documents relevant to the claim for benefits and to submit comments and documents relating to the claim, without regard to whether that information was submitted or considered in the initial benefit determination, prior to a decision being rendered. The Medical Director will determine the resolution for the complaint and respond in writing to the Member within fifteen (15) days from the date of receipt of pre-service requests and within thirty (30) days from the date of receipt of post-service requests, or as allowed by law.

Second Level Review (Voluntary Level)
Appeals
Should the Member decline to accept an adverse First Level Internal decision of his/her Appeal, the Member may request a second level voluntary review in writing. The Second Level Review is voluntary, meaning that the Member may choose to request an External Review after receipt of determination of the First Level Internal Decision. The Member must file a formal written request to the Appeals Committee within **thirty (30) days** of the adverse First Level Internal review decision. This can be faxed, mailed or hand-delivered.

The Appeals Committee will review all the information submitted by the Member. The Member will be notified in writing of the Appeals Committee decision within fifteen (15) days from the date of receipt of pre-service requests and within thirty (30) days from the date of receipt of post-service requests or as allowed by law.

Appeals may also be submitted to the Office of Consumer Services of the Louisiana Department of Insurance. Contact information is as follows:

Louisiana Department of Insurance
Office of Consumer Services
P.O. Box 94214
Baton Rouge, LA 70804-9214
Phone: (225) 219-0619 or (800) 259-5300
www.ldi.la.gov

Grievances
Vantage's Member Services department includes a Grievances team for Grievance research, responses, analytics and trends, which also serves as a resource for areas of improvement.

Grievance experiences are reviewed within Member Services and rarely require additional reviews. However, in the event that a Second Level Review is necessary, the Director of Member Services and other involved Vantage personnel shall review a Grievance to ensure appropriate actions and responses were provided to the Member.

Grievances may also be submitted to the Office of Consumer Services of the Louisiana Department of Insurance. Contact information is as follows:

Louisiana Department of Insurance
Office of Consumer Services
P.O. Box 94214
Baton Rouge, LA 70804-9214
Phone: (225) 219-0619 or (800) 259-5300
www.ldi.la.gov

Expedited Review
If a complaint involves an urgent care request, a Member or Authorized Representative may request a first or second level review orally or in writing. An urgent care request is one that should not be handled in the standard process because it could seriously jeopardize a Member's life or health or ability to regain maximum function. Or, would in the opinion of a Physician with knowledge of a Member's medical condition, subject the Member to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of a Member's request. All requests for urgent care submitted on a Member's behalf will be considered urgent and will be handled as soon as possible, taking into account a Member's medical situation, but in no case later than **seventy-two (72) hours** from receipt of the expedited review request.

Standard External Review
For matters involving an issue of Medical Necessity, appropriateness, health care setting, level of care, effectiveness or a Rescission of coverage, Members have the right for external review. This includes matters involving health care service or treatment determined to be experimental or investigational. Within **one hundred eighty (180) calendar days** from the receipt of a notice of an Adverse Determination or Final Adverse Determination, a Member or Authorized Representative may request an external review, regardless of the claim

amount. Also, an external review may be requested if Vantage has not issued a decision within thirty (30) days following the filing date of an initial Grievance or Appeal with Vantage, provided the Member has not requested or agreed to a delay. You or your Authorized Representative can send a request for an external review by mail to:

Vantage Health Plan, Inc.
Attn: External Appeal Review Request
130 DeSiard Street, Suite 300
Monroe, LA 71201
Phone: 1-888-823-1910
Fax: 1-318-361-2170

Within five (5) business days following the date of receipt of the external review request from the Member or Authorized Representative, Vantage will complete a preliminary review to determine whether the request is eligible for external review, based upon Louisiana RS 22:2436 (B). Within these five (5) days, Vantage will notify the Commissioner of Insurance, the Member and Authorized Representative, if applicable, that the request is complete and eligible for external review.

Should the request not be complete or is not eligible for external review, Vantage will provide written notification to the Member and Authorized Representative outlining the additional information needed or reasons for its ineligibility. Decisions regarding ineligibility may be appealed to the Commissioner of Insurance. The Commissioner may determine that a request is eligible for external review. If so, the Commissioner will notify Vantage and the Member or his Authorized Representative, if applicable, of this determination regarding eligibility within five (5) business days of the receipt of the request from the Member.

Once a case has been determined to be eligible for external review, Vantage will proceed with the following Independent Review Organization (IRO) process:

(1) Vantage will submit a request for assignment of an IRO by the Department of Insurance.
(2) The Commissioner will randomly assign an IRO from the list of approved IRO's compiled and maintained by the Commissioner to conduct the external review and will notify Vantage of the assigned IRO.
(3) Within one (1) business day, the Commissioner will send written notice to the Member and, if applicable, his Authorized Representative, of the request's eligibility and acceptance for external review and the identity and contact information of the assigned IRO. The Commissioner will include in the notice that the Member or Authorized Representative may submit additional information in writing to the assigned IRO within five (5) days of receipt of the notice of assignment.
(4) Vantage must provide to the IRO within five (5) business days the documents and any information considered in making the Adverse Determination or Final Adverse Determination.

The IRO will have **forty-five (45) days** after receipt of the request for an external review to issue a written notice of its decision to the Member; the Member's Authorized Representative, if applicable; Vantage and the Commissioner. If the decision is favorable for the Member, Vantage will immediately approve the coverage or payment that was the subject of the review.

Expedited External Review
An expedited external review is available to Members in either of the following scenarios:

1. An Adverse Determination issued and the Adverse Determination (a) involves a medical condition for which the time for completion of an expedited internal review of a Grievance involving Adverse Determination would seriously jeopardize the life or health of the Member or would jeopardize the Member's ability to regain maximum function and (b) the Member has simultaneously filed request for expedited internal Appeal of the Adverse Determination.

2. A Final Adverse Determination is issued and the Final Adverse Determination (a) involves a medical condition for which the time for completion of Standard External Review of the Final Adverse Determination would

seriously jeopardize the life or health of the Member or would jeopardize the Member's ability to regain maximum function OR (b) concerns a service/treatment for Emergency services and Member has not been discharged from facility.

The same process will be followed as outlined in the Standard External Review process; however, the time frames outlined will be changed to immediately and as expeditiously as the Member's medical condition or circumstances require. Upon receipt of an expedited external review request, Vantage will determine eligibility for review and then forward the request to LDI within twenty-four (24) hours. LDI shall then assign the review request to an LDI-appointed IRO for a coverage determination. The coverage determination must be made by the IRO within seventy-two (72) hours after the date Vantage receives the request. If the notification is provided orally and not in writing, within forty-eight (48) hours after the date of providing the notice, the IRO will provide written confirmation of the decision. If the decision is favorable to the Member, Vantage will approve the coverage that was subject of the review.

Formulary Exception Requests

For matters involving a denial of an exception request for a non-formulary Drug, Members have the right for external review. This exception process applies to Drugs that are not included on Vantage's formulary Drug list and this process is distinct from the above external review process for Drugs that are included on the formulary Drug list. Within **one hundred and eighty (180) days** from the receipt of a notice of an Adverse Determination, a Member or Authorized Representative may request an external review. After one hundred and eighty (180) days, you do not have the right to file an Appeal. You or your Authorized Representative can send a request for an external review by mail to:

Vantage Health Plan, Inc.
Attn: External Appeal Review Request
130 DeSiard Street, Suite 300
Monroe, LA 71201
Fax: 1-318-361-2170
Phone: 1-888-823-1910

If you request it, an Appeal will be conducted by an Independent Review Organization (IRO). An IRO is not connected in any way with Vantage. Vantage must go along with the IRO's decision and carry out its instructions. Members are not required to bear costs of the IRO, including any filing fees. If your claim is not eligible for independent external review you will receive a denial notification and further information on your Appeal rights to the Commissioner of Insurance. If you request an external review, an independent organization will review our decision and provide you with a determination no later than seventy-two (72) hours for standard review or twenty-four (24) hours for expedited reviews after receipt of information sufficient to begin the review. If this organization decides to overturn our decision, we will provide coverage or payment for your Drug.

The prescribing Physician or other prescriber should support the request by including an oral or written statement that provides justification supporting the need for the non-formulary Drug to treat your condition, including a statement that all covered formulary Drugs on any tier will be or have been ineffective, would not be as effective as the non-formulary Drug, or would have adverse effects.

You have the right to request an expedited external review based on urgent circumstances. Urgent circumstances exist when you are suffering from a serious health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or when you are undergoing a current course of treatment using a non-formulary Drug.

Once your external review is initiated, you will receive instructions on how to supply additional information. You are entitled to receive, upon request and at no additional cost, reasonable access to and copies of all documents relevant to the Appeal including new or additional evidence. You may also obtain a copy (free of charge) upon request, of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based.

Some prescription drugs on Vantage's formulary also require step therapy. If you disagree with Vantage's decision to deny a drug based on step therapy protocols, you may request a step therapy override request. Vantage will respond to standard step therapy exception requests within 72 hours. Expedited step therapy exception requests will be responded to within 24 hours of receipt. If Vantage fails to comply with the timelines, the override request shall be considered approved. If your override request is due to a condition associated with stage-four advanced metastatic cancer, the prescribing Physician or other prescriber should support the request by including an oral or written statement for supporting justification to ensure requirements as listed in La. R.S. 22:1053(J) are met.

Per Louisiana RS 22:2437, an expedited external review will not be provided for retrospective Adverse Determinations in which services have already been provided to a Member.

External Review decisions are binding on Vantage and the Member except to the extent that other remedies are available under applicable federal or state law.

DUPLICATE REQUESTS TO APPEAL THE SAME CLAIM, SERVICE, ISSUE, OR DATE OF SERVICE WILL NOT BE CONSIDERED.

SECTION XII: 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; or
- 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 visit the Department of Labor website's Fact Sheet on 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 XIII: WHCRA Notice

Pursuant to La. R.S. 22:1077.1, Vantage shall cover annual preventive cancer screenings for a Member who was previously diagnosed with breast cancer, completed treatment for breast cancer, underwent a bilateral mastectomy, and was subsequently determined to be clear of cancer.

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

Breast reconstruction includes all stages of reconstruction of the breast on which a mastectomy has been performed and on the other breast to produce a symmetrical appearance, including but not limited to:

- contralateral prophylactic mastectomies,
- liposuction performed for transfer to a reconstructed breast or to repair a donor site deformity,
- tattooing the areola of the breast,
- surgical adjustments of the non-mastectomized breast,
- unforeseen medical complications which may require additional reconstruction in the future,
- prostheses and physical complications, including but not limited to lymphedemas, and
- multilayer compression bandaging systems and custom or standard-fit gradient compression garments for the treatment of lymphedema.

These benefits are subject to authorizations and/or Cost Shares that are applicable to your medical 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. If you would like more information on WHCRA benefits, call the Vantage Member Services department at (318) 998-4371 or toll-free at (844) 833-7504.

SECTION XIV: 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 this 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. We are 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. This Notice 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 any information, including Genetic Information, which identifies an individual enrolled in a Vantage benefit Plan. It relates to the person's participation in the Plan, the person's past, present or future physical or mental health or condition, the provision of health care to that person, or the past, present or future payment for the provision of health care to that person. PHI also includes information which identifies the person or for which there is a reasonable basis to believe it could be used to identify the person. This information includes many common identifiers (e.g., name, address, birth date, social security number). 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 do we 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 website (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).

- Information we receive from the Centers for Medicare & Medicaid Services (CMS) and other authorized federal and state regulatory agencies.

How do we protect this information?
We have policies that limit internal and external sharing of PHI to only those 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. If there is a reportable breach of unsecured PHI, we will notify you.

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

- Perform certain duties, 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 as permitted by law (Genetic Information may not be used or disclosed for underwriting purposes); administration and coordination of reinsurance contracts.
- Operate preventive health programs, early disease 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), 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 with compliant business associate agreements.
  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.** De-identified means PHI that does not identify an individual and there is no reasonable basis to believe that the information could be used to identify an individual.

We consider the activities described above as essential for the operation of our health Plan. For example, we 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 and other Providers 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.
- 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 the Louisiana Department of Insurance, and CMS.
- For public health activities. We may report information to the Food and Drug Administration for investigating or tracking of Prescription Drug and medical device issues or problems.

- To public health agencies if we believe there is a serious health or safety threat.
- To 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. 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 otherwise 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 other government officials.
- For on the job-related injuries because of requirements of state workers' compensation laws.

We do 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**. For example, written authorization from you would be required for the use and/or disclosure of psychotherapy notes (if applicable) and the use of PHI for marketing purposes. Written authorization is also required for the "sale" of PHI as defined under 45 CFR Section 164.501. In the event that you are unable to provide the authorization (for example, if the Member is medically unable to give consent), we will accept authorization from any person legally authorized to give consent on behalf of the Member, such as a parent or guardian, or court-appointed representative. 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 us 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 we maintain about you in your designated record set. A "designated record set" is a group of records maintained by or for us 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 us to make decisions about you, such as Appeal and Grievance records. We 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 cannot provide you with copies of the following information:

- contained in psychotherapy notes; or
- compiled in reasonable anticipation of, or for use in a civil criminal or administrative action or proceeding.

We will do our best to respond to your request no later than thirty (30) days after we receive it. If, however, we are unable to fulfill your request within this 30 day period, we may extend the period to respond by an additional 30 days provided we have given you a timely explanation for the delay.

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. We will respond to your request no later than 30 days after we receive it. If we are unable to act within 30 days, we may extend that time by no more than an additional

30 days. If we need the extension, we will notify you of the delay, the reason for 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 through a written rebuttal. 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., physician, pharmacy, Hospital or other caregiver) that generated the original records, which could be more complete than any we maintain.

You have the right to receive an accounting of certain disclosures of your information made by us during the six (6) 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; or
- 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 30 days. If we need additional time to act on your request, we may take up to an additional 30 days. In connection therewith, we will provide you with a written statement of the reasons for the delay and the date by which we will provide the accounting. Your first accounting will be free, and we will continue to provide to you one free accounting upon request every twelve (12) months. However, if you request an additional accounting within 12 months of receiving your free accounting, we may charge you a fee. The fee will be reasonable and cost-based. 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. If we engage in any type of fundraising activity, you have the right to opt out of receiving any such communication.

You have the right to ask to receive confidential communications of information. We may require that your request include a statement that disclosure of all or part of the information to which the request pertains could endanger you or someone else. 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 do we do with Member PHI when the Member is no longer enrolled in our Plan?
We do not destroy PHI when individuals terminate their coverage. The information is necessary and used for many purposes as described in this Notice, 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 secure 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 our subscribers upon enrollment in a Vantage health plan. You can also view a copy of the Notice on our website 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 website.
- 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 our Privacy Officer at the address mentioned above or contact our 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
Local: (318) 998-4371
Toll-free: (844) 833-7504

SECTION XV: LLHIGA SUMMARY

Summary of the Louisiana Life and Health Insurance Guaranty Association Law and Notice Concerning Coverage Limitations and Exclusions

Residents of Louisiana who purchase life insurance, annuities, or health insurance should know that the insurance companies licensed in this state to write these types of insurance are required by law to be members of the Louisiana Life and Health Insurance Guaranty Association (LLHIGA). The purpose of LLHIGA is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this happens, LLHIGA will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state, and in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through LLHIGA is limited. As noted in the disclaimer below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

Disclaimer

The Louisiana Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. *COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.* Even if coverage is provided, there are significant limits and exclusions. Coverage is generally conditioned upon residence in this state. Other conditions may also preclude coverage.

Insurance companies and insurance agents are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on the availability of coverage under the Louisiana Life and Health Insurance Guaranty Association when selecting an insurer.

The Louisiana Life and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

LLHIGA	**Department of Insurance**
P.O. Box 3337	P.O. Box 94214
Baton Rouge, LA 70821	Baton Rouge, LA 70804-9214

The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Law (the law), and is set forth at R.S. 22:2081 *et seq.* The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change any person's rights or obligations under the law or the rights or obligations of LLHIGA.

Coverage

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a direct non-group life, health, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract, issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons may also be protected as well even if they live in another state unless they are afforded coverage by the guaranty association of another state, or other circumstances described under the law are applicable.

Exclusions from Coverage

A person who holds a direct non-group life, health, or annuity policy or contract, a certificate under a direct group policy or contract for a supplemental contract to any of these, or an unallocated annuity contract is not protected by LLHIGA if:

(1) He is eligible for protection under the laws of another state (This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state.);

(2) The insurer was not authorized to do business in this state;

(3) His policy was issued by a profit or nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, an insurance exchange, an organization that issues charitable gift annuities as is defined in R.S. 22:952(A)(3), or any entity similar to any of these.

LLHIGA also does not provide coverage for:

(1) Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

(2) Any policy of reinsurance (unless an assumption certificate was issued);

(3) Interest rate or crediting rate yields, or similar factors employed in calculating changes in value, that exceed an average rate;

(4) Dividends, Premium refunds, or similar fees or allowances described under the Law;

(5) Credits given in connection with the administration of a policy by a group contract holder;

(6) Employers', associations' or similar entities' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or uninsured;

(7) Unallocated annuity contracts (which give rights to group contract holders, not individuals), except unallocated annuity contracts and defined contribution government plans qualified under section 403(b) of the United States Internal Revenue Code (26 U.S.C. §403(b));

(8) An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the policy owner or contract owner, including but not limited to, claims described under the law;

(9) A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to "Medicare Part C coverage" or "Medicare Part D coverage" and any regulations issued pursuant to those parts;

(10) Interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer, whichever is earlier.

Limits on Amounts of Coverage

The Louisiana Life and Health Insurance Guaranty Association Law also limits the amount that LLHIGA is obligated to pay out. The benefits for which LLHIGA may become liable shall in no event exceed the lesser of the following:

(1) LLHIGA cannot pay more than what the insurance company would owe under a policy or contract if it were not an impaired or an insolvent insurer.

(2) For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance.

(3) For any one insured life, regardless of the number of policies or contracts there are with the same company, LLHIGA will pay a maximum of $500,000 in health insurance benefits, and LLHIGA will pay a maximum of $250,000 in present value of annuities, including net cash surrender and net cash withdrawal values.

In no event, regardless of the number of policies and contracts there were with the same company, and no matter how many different types of coverages, LLHIGA shall not be liable to expend more than $500,000 in the aggregate with respect to any one individual.

Vantage Health Plan is required by federal law to provide the following information.

Nondiscrimination Notice

Vantage complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, sexual orientation, or any other legally protected characteristic. Vantage does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, age, disability, sex, gender identity, sexual orientation, or any other legally protected characteristic.

Vantage provides free aids and services to people with disabilities to communicate effectively with us. Those services include qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, and other formats).

For people whose primary language is not English, Vantage provides free language translation services. Those services include qualified interpreters and information written in other languages. You can use Vantage's free language translation services by calling the "Members" phone number on the back of your Member ID card. For Members who are deaf or hard of hearing, please call for teletypewriter (TTY) services at 711.

If you believe that Vantage has failed to provide these services or has discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, sexual orientation, or any other legally protected characteristic, you can file a grievance with Vantage or the U.S. Dept. of Health and Human Services, Office for Civil Rights.

If you would like to file a complaint directly with Vantage, you can reach us in person, by mail, by fax, or by email at the addresses below:

Vantage Health Plan
Attention: Civil Rights Coordinator
130 DeSiard Street, Suite 300
Monroe, LA 71201
Phone: (318) 998-2887, TTY 711
Fax: (318) 361-2165
Email: *civilrightscoordinator@vhpla.com*

If you would like to file a complaint directly with the U.S. Dept. of Health and Human Services, Office for Civil Rights, you can contact them by mail, by phone, or by email at the addresses below:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
Phone: (800) 368-1019, (800) 537-7697 (TDD)
Online Complaint Portal: *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

If you need help filing a grievance, our Civil Rights Coordinator is available to help at *civilrightscoordinator@vhpla.com* or by phone at (318) 998-2887.

Vantage has adopted internal grievance procedures for providing prompt and equitable resolution of complaints alleging discrimination on the basis of race, color, national origin, age, disability, sex, gender identity, sexual orientation, or any other legally protected characteristic. Any person who believes someone has been subjected to discrimination on any of these grounds, may file a grievance under Vantage's grievance procedure. It is against the law for Vantage to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance. Depending on the type of grievance, a 60-day filing limit may apply. To learn more about Vantage's grievance procedure, you can call or email our Civil Rights Coordinator at the addresses above or you can visit our website at *www.vantagehealthplan.com/vhpnondiscriminationgrievanceprocedure*.

Language Assistance

If you, or someone you're helping, have questions about Vantage Health Plan, you have the right to get help and information in your preferred language at no cost. To talk with an interpreter, call Member Services, 888-823-1910 (TTY 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-823-1910 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 888-823-1910 (ATS: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 888-823-1910 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 888-823-1910 (TTY 711。

1910-823-888)مقر هاتف ةظوحلم: اذإ تنك ثدحتت اذكر اللغة، نإف خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم
.) 711 :مكبلاو مصلا

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 888-823-1910 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 888-823-1910 (TTY: 711) 번으로 전화해 주십시오.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 888-823-1910 (TTY: 711).

ໂປດຊາບ: ຖາວາ ທານເວາພາສາ ລາວ, ການບລການຊວຍເຫອດານພາສາ, ໂດຍບເສຽຄາ, ແມນມພອມໃຫ ທານ. ໂທຣ 888-823-1910 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。888-823-1910 (TTY: 711）まで、お電話にてご連絡ください。

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں
(TTY: 711) 888-823-1910

સચન◌ા: જો તમે ગજર◌ાતી બોલતા હ◌ો, તો નન:શલ◌્ક ભ◌ાષા સહાય સેવ◌ાઓ તમ◌ારા મ◌ાટ ઉપલબ્ધ છ◌ે. ફોન કરો 888-823-1910 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 888-823-1910 (TTY: 711)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم
می باشد. با (TTY: 711) 888-823-1910 تماس بگیرید.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 888-823-1910 (телетайп: 711).

เรยน: ถาคณพดภาษาไทยคณสามารถใชบรการชวยเหลอทางภาษาไดฟร โทร 888-823-1910 (TTY: 711).

VANTAGE HEALTH PLAN

OFFICE OF GROUP BENEFITS ogb LOUISIANA

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Monroe, LA 71201

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Toll-Free: (844) 833-7504

Fax: (318) 361-2159

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855 Pierremont Road, Suite 109

Shreveport, LA 71106

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BATON ROUGE ADDRESS

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