SCHEDULE OF BENEFITS
HMO POINT OF SERVICE
CONTRACT 13100 01140 0110R

GROUP NAME	GROUP NUMBER
East Baton Rouge Parish School System (EBRPSS)	77749 and Departments (Buy Up Plan)
GROUP'S ORIGINAL CONTRACT DATE	**GROUP'S ANNIVERSARY DATE**
January 1, 2006	January 1st
GROUP'S AMENDED CONTRACT DATE	
January 1, 2010	

SCHEDULE OF BENEFITS

Lifetime Maximum Benefit	$2,000,000.00
Benefit Period	Calendar Year for all providers

COPAYMENTS AND COINSURANCE

	NETWORK	NON-NETWORK	DEPENDENT OUT-OF-AREA
	Coinsurance shown as Group - Member responsibility **Copayments shown are the Member's responsibility**		
Outpatient visits for the following services: • Primary Care Physician's office visits for the following Physician and/or Provider specialties: • General Practice • Family Practice • Pediatrics • Internal Medicine • OB/GYN • Licensed Professional Counselor • Masters of Social Work • Physiotherapists • Psychiatrists • Psychologist • Substance Abuse Counselor	$20.00 per visit	70% - 30%	$20.00 per visit

• Speech Therapy, Physical Therapy, Occupational Therapy, Cardiac Rehabilitation	90% - 10%	70% - 30%	90% - 10%
• Preventive and Wellness Care	$20.00 for Primary Care Physicians $40.00 for Specialists	70% - 30% after Deductible	$20.00 for Primary Care Physicians $40.00 for Specialists
Outpatient visits for Specialists and Allied Health Professionals office visits for providers not included above	$40.00 per visit	70% - 30%	$40.00 per visit
Vision Care Exam, limited to 1 exam in a 24 month period (Optometrist only).	$20.00 per visit	$30.00 per visit	$20.00 per visit
Emergency Room or Out-of-Service Area Emergency	90% - 10%	70% - 30%	90% - 10%
Chiropractic Services	$40.00 per visit	70% - 30% after Deductible 20 visits each Benefit Period	$40.00 per visit
Ambulance Services	90% - 10%	70% - 30%	90% - 10%
Ambulatory Surgical Facility and Outpatient Surgical Facility	$100.00 per surgical visit	70% - 30%	$100.00 per surgical visit
Inpatient Hospital Admission, all Inpatient Hospital services included (Copayment is in addition to the Deductible Amount and the Deductible Amount is not reduced by the Copayment.)	$300.00 per Admission then 90% - 10%	70% - 30%	$300.00 per Admission then 90% - 10%
Physician's services for Pregnancy Care	$25.00 per pregnancy	70% - 30%	$25.00 per pregnancy
Durable Medical Equipment, Prosthetic Appliances and Orthotic Devices	80% - 20%	70% - 30%	80% - 20%

Inpatient and Outpatient services for which a Copayment is not applicable	90% - 10%	70% - 30%	90% - 10%
Services for: • Home Health Care, (limited to 75 visits each Benefit Period) • Hospice Care, (limited to 180 days Lifetime Maximum) • Skilled Nursing Facility, (limited to 60 days each Benefit Period)	90% - 10%	70% - 30%	90% - 10%
Contraceptive devices and contraceptive drugs (such as IUD, diaphragms, Depo Provera, Lunelle, Implannon implant) are covered when administered in a Physician's office.	90% - 10%	70% - 30%	90% - 10%
All other services	90% - 10%	70% - 30%	90% - 10%

MENTAL DISORDERS, ALCOHOL AND/OR DRUG ABUSE

NETWORK, NON-NETWORK AND DEPENDENT OUT-OF-AREA SERVICES

Coinsurance and Inpatient Hospital Copayments for Mental Disorders, Alcohol and/or Drug Abuse are the same as for any other illness

- The Member's Coinsurance for Mental Disorders, Alcohol and/or Drug Abuse **is eligible** for satisfying the Out-of-Pocket Amount.

	NETWORK	NON-NETWORK	DEPENDENT OUT-OF-AREA
Copayment or Coinsurance for Physician's office visit for Mental Disorders, Alcohol and/or Drug Abuse	$20.00 per visit; then 100% - 0%	70% - 30%	$20.00 per visit; then 100% - 0%

INPATIENT SERVICES	MAXIMUM
Mental Disorders, Alcohol and/or Drug Abuse	Benefits are payable same as any other illness

OUTPATIENT SERVICES	MAXIMUM
Mental Disorders, Alcoho1 and/or Drug Abuse	Benefits are payable same as any other illness

DEDUCTIBLE/OUT-OF-POCKET AMOUNT

	NETWORK	NON-NETWORK	DEPENDENT OUT-OF-AREA
Benefit Period Deductible Amount	$300.00	$1,000.00	$300.00
The Deductible Amount incurred for each Provider **is not** eligible for satisfying the Deductible amount for the other Provider.			
Out-Of-Pocket Amount Remaining Coinsurance incurred for Durable Medical Equipment, Prosthetic Appliances and Orthotic Devices provided by a Non-Network Provider is not eligible for satisfying the Out-Of-Pocket Amount. The Out-Of-Pocket Amount incurred for each Provider **is not** eligible for satisfying the Out-Of-Pocket Amount for the other Provider.	$2,000.00	$6,000.00	$1,700.00
Family Out-Of-Pocket Amount [Aggregate] The Out-Of-Pocket Amount incurred for each Provider **is not** eligible for satisfying the Out-Of-Pocket Amount for the other Provider.	$4,000.00	$12,000.00	$3,400.00

ORGAN, TISSUE AND BONE MARROW TRANSPLANTS

- Benefits are subject to applicable Deductible, Coinsurance, Inpatient and Outpatient Copayments.
- Organ, tissue and bone marrow transplants and evaluation for a Member's suitability for organ, tissue and bone marrow transplants will not be covered unless a Member obtains written Authorization from Us prior to services being rendered.
- Acquisition Expense Maximum accrues to the Lifetime Maximum Benefit.
- Organ, Tissue and Bone Marrow Transplant Maximum accrues to the Lifetime Maximum Benefit.
- Non-Network Benefits are not available for Organ, Tissue and Bone Marrow Transplants.

	NETWORK	DEPENDENT OUT-OF-AREA
Organ, Tissue Bone Marrow Transplant Maximum	Same as for any other illness	Same as for any other illness
Acquisition Expense Maximum	Same as for any other illness	Same as for any other illness

PRIVATE DUTY NURSING

Outpatient Private Duty Nursing services are limited to a Benefit Period maximum of $5,000.00 for each member.

DURABLE MEDICAL EQUIPMENT, ORTHOTIC DEVICES AND PROSTHETIC APPLIANCES

Benefits for Durable Medical Equipment, Orthotic Devices and Non-Limb Prosthetic Appliances are limited to an aggregate maximum amount $15,000.00 each Benefit Period for each member. Benefits for Prosthetic Appliances and Devices and Prosthetic Services of the limbs are limited to a maximum amount of $50,000.00 per limb per year.

DIETICIAN VISITS

Benefits are limited to a maximum of $250.00 in Allowable Charges per Benefit Period for each Member.

AUTISM SPECTRUM DISORDERS

ASD Benefit Period Maximum (until 17th birthday) $36,000.00
ASD Benefit Period Maximum (age 17 and older)……$10,000.00
ASD Lifetime Maximum...$144,000.00

AUTHORIZATION OF ADMISSIONS

- **All Admissions must be Authorized by Us prior to the Admission to receive Network Benefits. The Network Provider MUST obtain Authorization from Us prior to the service being rendered and prior to the Admission. Failure to obtain Authorization by the Network Provider will result in a $1,000.00 payment reduction by Us toward the Allowable Charge to the Network Provider. The Member remains responsible for his applicable Copayment, Deductible Amount, and Coinsurance percentage shown above.**

- **The Member may be responsible for additional amounts other than his Deductible and Coinsurance if the Member is admitted to a Non-Network Provider facility and fails to obtain prior Authorization from Us.**

- **For Members enrolled for Dependent Out-of-Area Benefits, if Authorization of an Admission is not requested, the Member's claim may be reviewed for Medical Necessity. If it is determined that the Admission is not Medically Necessary, the Admission will not be covered and the Member must pay all charges.**

- **Requests for Authorization of all Admissions and for Concurrent Review of an Admission in progress must be made to HMO Louisiana, Inc. by calling 1-800-376-7973.**

- **If a request for Authorization or Concurrent Review is denied, the Admission will not be covered.**

AUTHORIZATION FOR OUTPATIENT SERVICES AND SUPPLIES

The following Outpatient services and supplies require Authorization prior to services being rendered to receive Network Benefits.

If Authorization is not requested prior to a listed service being rendered or a listed supply being received, We will have the right to determine if the service or supply was Medically Necessary. If the service or supply was Medically Necessary, Benefits will be provided based on the participating status of the Provider of the service or supply. If a Network Provider fails to obtain a required Authorization, We will reduce his Benefit payment by thirty percent (30%) of the Allowable Charge. This penalty applies to all services and supplies requiring an Authorization, other than Inpatient charges. The Network Provider is responsible for all charges not covered and for the penalty amount. The Member remains responsible for his applicable Copayment, Deductible amounts and Coinsurance percentage. If a service or supply was not Medically Necessary, the service or supply is not covered.

If the Member receives services and supplies from a Non-Network Provider, the Member is responsible for ensuring that the Provider contacts Us and obtains Authorization prior to the listed services being rendered or listed supplies being received. Failure by the Provider to obtain prior Authorization from Us will result in a benefit reduction payment by Us toward the Allowable Charge. The Member will be responsible for all charges not paid by Us in addition to his Deductible and/or Coinsurance amounts.

- **Requests for Authorization must be made to HMO Louisiana, Inc. by calling 1-800-376-7973.**

- Refer to the "Authorization of Services" section in this Contract for complete information.
  - Alcohol and Drug Services
  - Bone growth stimulator
  - Cardiac Rehabilitation
  - CT Scans
  - Durable Medical Equipment (greater than $200.00)
  - Home Health Care
  - Hospice Care
  - Implantable Medical Devices over $2000.00 such as Implantable Defibrillator and Insulin Pump
  - Mental Health Services
  - M.R.I./M.R.A.
  - Non-Emergency Ambulance
  - Nuclear Cardiology
  - Occupational Therapy
  - Orthotic Devices
  - All outpatient surgical procedures not performed in a Physician's office
  - PET/SPECT Scans
  - Physical Therapy
  - Private Duty Nursing
  - Prosthetic Appliances (greater than $500.00)
  - Speech Therapy
  - Sleep Studies
  - Stereotactic Radiosurgery, including but not limited to gamma knife and cyberknife procedures
  - Vacuum Assisted Wound Closure Therapy
  - Medical Nutritional Education/Therapy for Diabetes
  - Skilled Nursing Facility Services
  - Applied Behavior Analysis

ELIGIBILITY WAITING PERIOD

Article II. "Schedule of Eligibility" Section A. "Employees" Subsection 6.b. "Pre-Existing Conditions – New Employees" is deleted in its entirety and will read as follows:

New Employees (and their eligible Dependents) who apply for coverage with the Group within thirty (30) days of becoming eligible to participate in the Group's health care plan are not subject to a Pre-Existing Conditions Waiting Period. New Employees (and their eligible Dependents) who do not apply for coverage with the Group within thirty (30) days of becoming eligible to participate in the Group's health care plan are subject to the twelve (12) month Pre-Existing Condition Exclusion Waiting Period as described in the Benefit Plan.

New Employees (and their eligible Dependents) will be subject to all other conditions and provisions set forth in the Benefit Plan.

Article II. "Schedule of Eligibility" Section B. "Retirees" is amended to include the following provision:

Retired participants of the EBRPSS medical plans and their covered dependent spouses, who reach age sixty-five (65) on or after June 1, 2005, must enroll in Medicare Parts A and B in order for their claims to be paid under this Plan. If a retired participant or covered spouse are eligible for Medicare, but do not enroll for Parts A and B, the claims of the person eligible for Medicare will be denied.

Medicare pays primary coverage for those retired participants and their covered dependent spouses who are enrolled in Parts A and B. The EBRPSS medical plan will pay secondary to Medicare for such persons. The retired participant's claim cannot be processed until the EBRPSS medical plan claims administrator receives an explanation of benefits from Medicare indicating what Medicare paid as primary coverage.

The above provisions do not apply to a covered dependent spouse under age sixty-five (65) or the dependent children of a retired participant age sixty-five (65) or over. The above provisions also do not apply to non-Medicare eligible retired participants who are under age sixty-five (65) and their covered dependents. Coverage for such persons will continue to be provided as primary under the EBRPSS medical plans.

Retired participants not entitled to Medicare Parts A and B must supply EBRPSS the appropriate documentation from the Social Security Administration evidencing denial of entitlement. The EBRPSS medical plan in force will continue to provide primary coverage for retired participates who are not entitled to Medicare.

See the Schedule of Eligibility in the Benefit Plan for complete information regarding Eligibility Waiting Periods.

PRE-EXISTING CONDITION EXCLUSION PERIOD

The exclusion for a Pre-Existing Condition is applicable as stated in 'Limitations And Exclusions'. A Member may receive credit toward this exclusionary period for any time he served toward a Pre-Existing Conditions exclusionary period under his prior coverage. See the Benefit Plan for complete details.