

**ASO COMPREHENSIVE MEDICAL BENEFIT PLAN
(40XX1354 R01/10)
SCHEDULE OF BENEFITS**

<u>GROUP NAME</u>		<u>GROUP NUMBER</u>
East Baton Rouge Parish School System		77749 (PPO Buy Up Plan)
<u>GROUP'S ORIGINAL EFFECTIVE DATE</u>	<u>GROUP'S AMENDED BENEFIT PLAN DATE</u>	<u>GROUP'S ANNIVERSARY DATE</u>
January 1, 2006	January 1, 2010	January 1st

Lifetime Maximum: \$2,000,000.00 per Member

Benefit Period Deductible Amount (Individual):

PPO Preferred Providers	\$300.00
All Other Providers	\$1,000.00

The Deductible Amount incurred for each Provider **is not** eligible for satisfying the Deductible Amount for the other Provider.

The Benefit Period Deductible Amount does not apply to the following:

Eligible Vision Care Services

Coinsurance:	<u>Group</u>	<u>Member</u>
PPO Preferred Providers of the Preferred Care Network	90%	10%
All other Providers	70%	30%

Special Coinsurance:

Durable Medical Equipment, Prosthetics and Orthotic Devices	80%	20%
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Special Notes:

Benefits will be provided at one hundred percent (100%) of the Allowable Charge if a Copayment has been applied for Outpatient services.

Benefits will be provided at ninety percent (90%) of the Allowable Charge if a Copayment has been applied for Inpatient services.

Benefits will be provided at ninety percent (90%) of the Allowable Charge if a Deductible has been applied until the Out-of-Pocket Amount has been reached. Thereafter, Benefits will be provided at one hundred percent (100%) of the Allowable Charge for the remainder of the Benefit Period for each Member.

Out-of-Pocket Amount - Does NOT include the Deductible Amount or Copayments:

Individual	
Preferred Providers	\$2,000.00
All Other Providers:	\$6,000.00

Family	
PPO Preferred Providers	\$4,000.00
All Other Providers	\$12,000.00

Special Notes:

The Out-of-Pocket Amount incurred for each Provider **is not** eligible for satisfying the Out-of-Pocket Amount for the other Provider.

When services are performed by other than a Preferred Provider, the remaining Coinsurance for Durable Medical Equipment, Orthotic Devices and Prosthetic Appliances **is not** eligible for satisfying the Out-of-Pocket Amount.

Physician’s Office Visit Copayment: \$20.00 per visit for Primary Providers
 (Services must be provided by one of the following) \$40.00 per visit for all other Providers

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

Inpatient Facility Copayment (Preferred Providers) \$300.00 for each Admission

The above Copayment Amount is in addition to the Benefit Period Deductible Amount and the Benefit Period Deductible Amount is not reduced by this Copayment Amount.

Outpatient Facility Copayment (Preferred Providers only): \$100.00 per visit

Pregnancy Care Copayment (Preferred Providers only): \$25.00 per pregnancy
 All Benefits for maternity and/or Pregnancy Care services are subject to other limitations stated in the Benefit Plan.

Vision Care Copayment: \$20.00 per visit (Preferred Providers)
 (Optometrist only) \$30.00 per visit (all other Providers)

Chiropractic Services:
 Preferred Providers: \$40.00 per visit (then 100%/0%)
 All Other Providers: Up to twenty (20) visits each Benefit Period, subject to applicable Deductible and Coinsurance

Skilled Nursing Facility:

Benefits are limited to a Benefit Period maximum of sixty (60) days for each Member.

Home Health Care:

Benefits are limited to a Benefit Period maximum of seventy-five (75) visits for each Member.

Hospice Care:

Benefits are limited to a lifetime maximum of one hundred eighty (180) days for each Member.

Private Duty Nursing Services: (Authorization is required prior to services being performed)

Outpatient services are limited to a Benefit Period maximum of \$5,000.00 for each Member.

Preventive or Wellness Care:

Preferred Providers (Deductible Amount does not apply)	\$20.00 per visit
All Other Providers:	Subject to Deductible Amount and applicable Coinsurance

Durable Medical Equipment, Orthotic Devices, and Non-Limb Prosthetic Appliances and Devices

Aggregate Benefit Period Maximum: \$15,000.00

Prosthetic Appliances and Devices of the Limb and Prosthetic Services of the Limb

Maximum Benefit per Limb per Year: \$50,000.00

Dietician Visits:

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

Organ, Tissue, and Bone Marrow Transplant Benefits (Authorization required prior to services being performed):

Lifetime Maximum for all covered transplants combined:	None
Benefits paid will accrue to the overall Lifetime Maximum Benefit shown above	

Acquisition Expense Maximum per covered transplant:	None
Benefits paid will accrue to the overall Lifetime Maximum Benefit shown above	

Mental Disorders, Alcohol and/or Drug Abuse:

Benefits are payable same as any other illness

Rehabilitative Care Services:

Physical Therapy, Occupational Therapy, and/or Speech Language/Pathology Therapy is covered the same as any other illness under this Benefit Plan for each Member. No maximums are applicable.

Autism Spectrum Disorders:

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

Contraceptive Devices and Contraceptive Drugs:

Contraceptive devices and contraceptive drugs (such as IUD, diaphragms, Depo Provera, Lunelle, Implanon implant) are covered when administered in a Physician's office.

AUTHORIZATION OF SERVICES AND SUPPLIES

Authorization of Inpatient and Emergency Admissions:

Inpatient Admissions must be Authorized. Refer to “Authorization of Services and Supplies” and if applicable “Pregnancy Care Benefits” sections of the Benefit Plan for complete information. Requests for Authorization of Inpatient Admissions, for Concurrent Review of an Admission in progress, or other Covered Services and supplies must be made to Blue Cross and Blue Shield of Louisiana by calling 1-800-392-4076.

Benefits will be reduced by thirty percent (30%) of the Allowable Charge if Authorization of an Inpatient Admission is not requested.

Authorization of Outpatient Services, Including Other Covered Services and Supplies:

The following services and supplies require Authorization prior to the services being rendered or supplies being received.

- 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
- Medical Nutritional Education/Therapy for Diabetes
- Skilled Nursing Facility Services
- Stereotactic Radiosurgery, including but not limited to gamma knife and cyberknife procedures
- Vacuum Assisted Wound Closure Therapy
- Applied Behavior Analysis

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 contracted Provider in Louisiana’s Preferred Care (or PCare) Network 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 Preferred Care Provider is responsible for all charges not covered and for the penalty amount. The Member remains responsible for his Copayment, Deductible amount and applicable Coinsurance percentage. If a service or supply was not Medically Necessary, the service or supply is not covered.

Refer to the “Authorization of Services and Supplies, and if applicable, Pregnancy Care Benefits section of the Benefit Plan for complete information.

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 participants 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 the “Limitations and Exclusions” article of the Benefit Plan. A Member may receive credit toward this exclusionary period for any time he served toward a Pre-Existing Condition Exclusion Period under his prior coverage.