ST. TAMMANY PARISH SCHOOL BOARD

SCHEDULE OF BENEFITS

PLAN NAME		GROUP NUMBER
St. Tammany Parish School Board – Retiree Employee Plan Blue Connect EPO		78B03ERC
PLAN'S ORIGINAL BENEFIT PLAN DATE	**PLAN'S AMENDED BENEFIT PLAN DATE**	**PLAN'S ANNIVERSARY DATE**
January 1, 2007	January 1, 2023	January 1st

BENEFIT PERIOD:	Calendar Year - January 1 through December 31

DEDUCTIBLE:	**Blue Connect EPO PROVIDERS**	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
Individual Deductible Amount:	$300.00	$500.00	$500.00
Family Deductible Amount:	$600.00	$1,000	$1,000

SPECIAL NOTES:

- A Plan Participant does not have to meet the Individual Deductible Amount to be eligible for the Family Deductible Amount.
- To the extent required by federal law, cost sharing for Non-Emergency Services performed by Non-Network Providers at Network facilities will be at the Network level and based on the recognized amount.
- Benefits for services of Network Providers that accrue to the Deductible Amount for Network Providers WILL accrue to the Deductible Amount for Blue Connect (EPO) Providers.
- Benefits for services of a Blue Connect (EPO) Provider that accrue to the Deductible Amount for Blue Connect (EPO) Providers WILL accrue to the Deductible Amount for Blue Connect Network Providers.
- Benefits for services of Non-Network Providers that accrue to the Deductible Amount for Non-Network Providers WILL accrue to the Deductible Amount for Blue Connect (EPO) and Network Providers.
- Benefits for Non-Emergency Services performed by a Non-Network Providers at Network facilities WILL accrue to the Deductible Amount for Network Providers.

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

- Services for which a Copayment is applicable.
- Inpatient Well Newborn Care (Network)
- Mandated benefits for hearing aids for covered members aged 17 and under (All Providers)
- Pre-Admission Testing (Network
- Preventive or Wellness Care (Network)

OUT-OF-POCKET AMOUNT – Includes the Deductible, Coinsurance and Copayments.	**Blue Connect EPO PROVIDERS**	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
Individual:	$2,500	$2,750	$2,750
Family:	$5,000	$5,500	$5,500

SPECIAL NOTES:

- Benefits for services of a Network Providers that accrue to the Out-of-Pocket Amount for Network Providers WILL also accrue to the Out-of-Pocket Amount for Blue Connect (EPO) Providers.
- Benefits for services of a Blue Connect (EPO) that accrue to the Out-of-Pocket Amount for EPO Providers WILL also accrue to the Out-of-Pocket Amount for Network Providers.
- Benefits for services of Non-Network Providers that accrue to the Out-of-Pocket Amount for Non-Network Providers WILL accrue to the Out-of-Pocket Amount for Network or Blue Connect (EPO) Providers.
- To the extent required by federal law, cost sharing for Non-Emergency Services performed by Non-Network Providers at Network facilities will be at the Network level and based on the recognized amount.

MEDICAL BENEFITS – COPAYMENTS AND COINSURANCE:			
Coinsurance shown as Company - Plan Participant responsibility Copayments shown are the Plan Participant responsibility.	**Blue Connect Providers (EPO)**	**NETWORK**	**NON-NETWORK**
Inpatient and Outpatient Facility and Professional Services for Which a Copayment is not Applicable:	90% - 10%	90% - 10%	70% - 30%
	Blue Connect Providers (EPO)	**NETWORK**	**NON-NETWORK**
Primary Care Office Visits for the following Providers:	$25.00 Copayment per visit	$30.00 Copayment per visit	70% - 30%
Family Practice			
General Practice			
Geriatricians			
Internal Medicine			
Nurse Practitioner			
Pediatricians			
Physician Assistant			
Retail Health Clinic			
Specialists Office Visits for the following Allied Health Professionals:	$ 35.00 Copayment per visit	$45.00 Copayment per visit	70% - 30%
Audiologist			
Certified Mid-Wife			
Licensed Clinical Social Worker			
Obstetrician / Gynecologist			
Ophthalmologist			
Optometrist			
Osteopath			
Podiatrist			
Psychiatrist			
Psychologist			
Registered Dietitian			
Inpatient Hospital Admission: Includes Facility and Professional / Physician Services.	90% - 10%	90% - 10%	70% - 30%
Emergency Ambulance Services:			
Air Ambulance Services:	90% - 10%	90% -10%	90% -10%
Ground Ambulance Services:	90% - 10%	90% -10%	90% - 10%
Ambulatory Surgical Center and Outpatient Surgical Facility: Includes Facility and Professional / Physician Services.	90% - 10%	90% - 10%	70% - 30%
Bariatric Surgery Services	90% - 10%	90% - 10%	Not Covered
Emergency Medical Services: Includes Facility and Professional/Physician Services.	90% - 10%	90% - 10%	90% - 10%
Non-Emergency Medical Services –Includes Facility and Professional/Physician Services.	90% - 10%	90% - 10%	70% - 30%

Home Health Care: Limited to 150 visits per Plan Participant each Benefit Period.	90% - 10%	90% - 10%	70% - 30%
Hospice Care: Limited to 360 days (Inpatient and Outpatient combined) per Plan Participant per Lifetime.	90% - 10%	90% - 10%	70% - 30%
Mental Health and Substance Use Disorder:			
Office Visit for Mental Health and Substance Use Disorder Benefits	$35.00 Copayment per visit	$45.00 Copayment per visit	70% - 30%
Outpatient Mental Health and Substance Use Disorder Benefits (Includes Office Visits, Outpatient Facility and Outpatient Therapies)	100% Deductible Waived	100% Deductible Waived	70% - 30%
Inpatient Mental Health and Substance Use Disorder Benefits (Includes Facility and Professional/Physician Services)	90% - 10%	90% - 10%	70% - 30%
Organ, Tissue, and Bone Marrow Transplants: • Authorization required prior to services being performed. • Lodging, Meals and Transportation Benefits limited to: • $10,000 per Participant per Lifetime • $50 per diem rate for patient and one (1) individual • $100 per diem rate for patient and two (2) individuals	90% - 10%	90% - 10%	70% - 30%
Orthotic Appliances: • Limited as specified by the Plan. • Custom built orthopedic shoes are limited to one (1) pair per Plan Participant each Benefit Period.	90% - 10%	90% - 10%	70% - 30%
Pre-Admission Testing:	90% - 10%	100% Deductible Waived	70% - 30%
Pregnancy Care: Includes Physician services only. Pregnancy Care Services received from other Providers (such as a Hospital, Emergency Room, Urgent Care Center or Ambulatory Surgical Center), are subject to the applicable Copayments or Coinsurance shown for each, if any. Benefits are available to an Employee or Dependent wife of an Employee whose coverage is in effect at the time such services are furnished in connection with her pregnancy.	$35.00 Copayment then 90%-10%	$45.00 Copayment Then 90%-10%	70% - 30%
Preventive or Wellness Care: See the "Preventive or Wellness Care" Article for more details on Preventive or Wellness Care Benefits.	90% - 10%	100% Deductible Waived	Not Covered
Private Duty Nursing: • Inpatient Services Only. • Limited as specified by the Plan.	90% - 10%	90% - 10%	70% - 30%
Low-Tech Imaging, Laboratory Tests and High-Tech Imaging:			
Low-Tech Imaging and Laboratory Tests – Imaging Services which include, but are not limited to, x-rays, machine tests and diagnostic imaging			
Performed within the office or clinic of a Network Provider that is subject to the Office Visit Copayment.	100% Deductible Waived	100% Deductible Waived	70% - 30%
Performed within a Network Independent Lab.	90% - 10%	90% - 10%	70% - 30%
High-Tech Imaging – include but not limited to: CT Scans, MRIs MRAs, PET Scans or Nuclear Cardiology.	90% - 10%	90% - 10%	70% - 30%

Rehabilitative Care Services:			
• Physical Therapy and Occupational Therapy	90% - 10%	90%- 10%	70%- 30%
• Speech Therapy, including developmental Speech Therapy	90% - 10%	90%- 10%	70%- 30%
• Chiropractic Services	90% - 10%	90%- 10%	70%- 30%
Skilled Nursing Facility: Available within 14 days of a 3-day hospital stay.	90% - 10%	90% - 10%	70% - 30%
Temporomandibular / Craniomandibular Joint Dysfunction (TMJ): Limited to: • $600 of Allowable Charges per Participant per lifetime • Splint and panorex x-ray only	90% - 10%	90% - 10%	70% - 30%
Urgent Care Center:	**$**40.00 Copayment per visit	$50.00 Copayment per visit	$50.00 copayment per visit
Vision Care Exam: Limited to one (1) exam, including refractions, per Plan Participant each Benefit Period.	$25 Copayment	$30 Copayment	Not Covered
Wig after Chemotherapy: Limited to one (1) wig per Plan Participant per Lifetime.	90% - 10%	90% - 10%	70% - 30%

PRESCRIPTION DRUG COVERAGE:

BLUE CROSS AND BLUE SHIELD OF LOUISIANA DOES NOT PROVIDE CLAIMS PAYMENT SERVICES FOR PRESCRIPTION DRUGS EXCEPT FOR THOSE PRESCRIPTION DRUGS ADMINISTERED DURING AN INPATIENT OR OUTPATIENT STAY OR THOSE REQUIRING ADMINISTRATION BY A HEALTHCARE PROFESSIONAL IN A PHYSICIAN OFFICE. THE PLAN PARTICIPANT'S PHYSICIAN MUST CALL 1-800-842-2015 TO OBTAIN THE AUTHORIZATION. THE PLAN PARTICIPANT CAN CALL THE CUSTOMER SERVICE NUMBER ON THE BACK OF BACK OF HIS ID CARD OR CHECK THE CLAIMS ADMINISTRATOR'S WEBSITE AT **www.bcbsla.com/pharmacy** TO SEE IF THE CATEGORIES OF PRESCRIPTION DRUGS REQUIRING PRIOR AUTHORIZATION HAVE CHANGED.

Special Note:

There is no coverage under this medical benefit plan for OTC Covid-19 tests. Please contact Your Plan or Your Plan's Pharmacy Benefit Manager for information on coverage for OTC Covid-19 tests.

CARE MANAGEMENT

Requests for Authorization must be made to Blue Cross and Blue Shield of Louisiana by calling **1-800-376-7973.**

If a required Authorization is not requested prior to Admission or receiving other Covered Services and supplies, the Plan will have the right to determine if the Admission or other Covered Services or supplies were Medically Necessary.

If the Admission or other Covered Services and supplies were not Medically Necessary, the Admission or other Covered Services and supplies will not be covered, and the Plan Participant must pay all charges incurred.

If the Admission or other Covered Services and supplies were Medically Necessary, Benefits will be provided based on the participating status of the Provider rendering the services.

Authorization of Inpatient and Emergency Admissions:

Inpatient Admissions and Emergency Admissions must be Authorized. Refer to Care Management Article and if applicable Pregnancy Care and Newborn Care Benefits Article of the Benefit Plan for complete information. Requests for Authorization of Inpatient Admissions, Emergency Admissions and for Concurrent Review of an Admission in progress must be made to Blue Cross and Blue Shield of Louisiana by calling 1-800-523-6435.

If a Network Provider fails to obtain a required Authorization, We will reduce Allowable Charges by the penalty stipulated in the Provider's contract with Us or with another Blue Cross and Blue Shield plan. The Network Provider is responsible for the penalty and all charges not covered. The Plan Participant remains responsible for the applicable Copayment, Deductible Amount and Coinsurance.

Additional Plan Participant responsibility if Authorization is not requested for an Inpatient Admission to a Network Provider Hospital: **$500.00 reduction of the Allowable Charges.**

If a Non-Network Provider fails to obtain a required Authorization, the Plan Participant is responsible for all charges not covered, and for any applicable Copayment, Deductible Amount and Coinsurance.

Authorization of Outpatient Services and Supplies:

There is no penalty if a Network Provider fails to obtain a required Authorization. The Plan Participant remains responsible for any applicable Copayment, Deductible Amount and Coinsurance.

If a Non-Network Provider fails to obtain a required Authorization, the Plan Participant is responsible for all charges not covered and for any applicable Copayment, Deductible Amount and Coinsurance.

The following Outpatient Services and supplies require Authorization prior to the services being rendered or supplies being received. The list of services requiring Authorization may change from time to time. Providers may request a pre-determination of Medical Necessity prior to rendering services. Requests for Authorization or a pre-determination of Medical Necessity must be made to Blue Cross Blue Shield of Louisiana by calling 1-800-376-7973.

- Air Ambulance (Non-Emergency) (No Benefit Without Prior Authorization)
- Applied Behavior Analysis
- Bariatric Surgery
- Bone growth stimulator
- Cardiac Rehabilitation
- Cellular Immunotherapy
- Day Rehabilitation Programs
- Durable Medical Equipment (Greater than $1,000.00)
- Electric & Custom Wheelchairs
- Gene Therapy
- Genetic or Molecular Testing
- Food or food supplements, formulas and medical foods
- Home Health Care
- Hospice
- Hyperbarics
- Implantable Medical Devices over $2000.00, (including but not limited to defibrillators)
- Low Protein Foods
- PET scans
- Prosthetic Appliances
- Pulmonary Rehabilitation
- Skilled Nursing Facility
- Sleep studies, except those performed as a home sleep study
- Specialty Pharmacy
- Transplant Evaluation & Transplants

ELIGIBILITY WAITING PERIOD
The Plan Administrator will determine the Eligibility Waiting Period and Effective Date of coverage for all eligible Employees and their Dependents.
Active Employees: If an Employee is hired on the 1st of the month, coverage is effective that day.
Elected Officials: Eligible Persons who satisfy the Eligibility requirements as specified by the Plan and who are eligible to participate in the Group's healthcare Benefit Plan.
Under no circumstances will the initial Eligibility Waiting Period ever exceed ninety (90) days following the date of hire.