

ST. TAMMANY PARISH SCHOOL BOARD

SCHEDULE OF BENEFITS

Plan Name:		Group Number:
St. Tammany Parish School Board – EPO PPO		78B03ERC
Network:		Plan Type:
Preferred Care		PPO
Plan’s Original Benefit Date:	Plan’s Amended Benefit Date:	Plan’s Anniversary Date:
January 1, 2007	January 1, 2025	January 1 st
Benefit Period:	Calendar Year – January 1 st through December 31 st	

MEDICAL DEDUCTIBLE AMOUNTS:

<i>Deductible Amounts listed apply to the 2025 Benefit Period.</i>	BLUE CONNECT EPO PROVIDERS	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Individual Deductible Amounts:	\$600.00	\$800.00	\$800.00
Family Deductible Amounts:	\$1,200.00	\$1,600.00	\$1,600.00
Special Notes:			
<ul style="list-style-type: none"> • 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 or a lesser amount established by Us. 			
Deductible Accrual:			
<ul style="list-style-type: none"> • Benefits for services of a Blue Connect (EPO) Provider that accrue to the Deductible Amount for Blue Connect (EPO) Providers WILL ALSO accrue to the Deductible Amount for Network and Non-Network Providers. • Benefits for services of Network Providers that accrue to the Deductible Amount for Network Providers WILL ALSO accrue to the Deductible Amount for Blue Connect (EPO) Providers and Non-Network Providers. • Benefits for services of Non-Network Providers that accrue to the Deductible Amount for Non-Network Providers WILL ALSO accrue to the Deductible Amount for Blue Connect (EPO) and Network Providers. • Benefits for Emergency Medical Services of Non-Network (Participating and Non-Participating) Providers WILL accrue to the Deductible Amount for Network Providers. • Benefits for Non-Emergency Services performed by 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:			
<ul style="list-style-type: none"> • Mental Health Outpatient Services (Blue Connect EPO & Network Providers) • Substance Use Outpatient Services (Blue Connect EPO & Network Providers) • Preventive or Wellness Care (Blue Connect EPO & Network Providers) • Office Low-Tech Imaging Services (Blue Connect EPO & Network Providers) 			

OUT-OF-POCKET AMOUNTS:

<i>The following accrue to the Out-of-Pocket Amounts: Copayments, Deductible Amounts and Coinsurance.</i>	BLUE CONNECT EPO PROVIDERS	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Individual Out-of-Pocket Amounts:	\$2,500.00	\$2,750.00	\$2,750.00
Family Out-of-Pocket Amounts:	\$5,000.00	\$5,500.00	\$5,500.00

Special Notes:

- 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 or a lesser amount established by Us.

Out-of-Pocket Accrual:

- Benefits for services of Blue Connect (EPO) Providers that accrue to the Out-of-Pocket Amount for Blue Connect (EPO) Providers WILL ALSO accrue to the Out-of-Pocket Amount for Network Providers and Non-Network Providers.
- Benefits for services of 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 and Non-Network Providers.
- Benefits for services of Non-Network Providers that accrue to the Out-of-Pocket Amount for Non-Network Providers WILL ALSO accrue to the Out-of-Pocket Amount for Blue Connect (EPO) Providers and Network Providers.
- Benefits for Emergency Medical Services of Non-Network (Participating and Non-Participating) Providers WILL accrue to the Out-of-Pocket Amount for Network Providers.
- Benefits for Non-Emergency Services performed by Non-Network Providers at Network facilities WILL accrue to the Out-of-Pocket Amount for Network Providers.

MEDICAL BENEFITS – OFFICE VISIT COPAYMENTS			
<i>Copayments shown are the Plan Participant's responsibility per visit. Office Visit Copayments only apply to EPO and Network Providers.</i>	BLUE CONNECT EPO PROVIDERS	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Primary Care Provider Office Visit copayment for the following Providers:	\$25.00 per visit	\$30.00 per visit	70% - 30%
Doula Services are limited to Network providers only. Non-Network providers are not covered.			Not Covered
Family Practice			
General Practice			
Geriatrics			
Internal Medicine			
Nurse Practitioner			
Pediatrics			
Physician Assistant			
Retail Health Clinic			
Specialists Office Visit copayment for all other Providers:	\$ 35.00 per visit	\$45.00 per visit	70% - 30%

MEDICAL BENEFITS – COPAYMENTS & COINSURANCE			
<i>Coinsurance shown as Company – Plan Participant responsibility. Copayments shown are the Plan Participant's responsibility.</i>	BLUE CONNECT EPO PROVIDERS	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Ambulance Services:			
Air Ambulance Services	90% - 10%	90% - 10%	90% - 10%
Emergency Ground Ambulance Services In-State	90% - 10%	90% - 10%	90% - 10%
Emergency Ground Ambulance Services Out-of-State	90% - 10%	90% - 10%	90% - 10%
Non-Emergency Ground Ambulance Services	90% - 10%	90% - 10%	90% - 10%

Ambulatory Surgical Center and Outpatient Surgical Facility: Includes all Surgical Professional and Physician Charges.	90% - 10%	90% - 10%	70% - 30%
Bariatric Surgery Services:	90% - 10%	90% - 10%	Not Covered
Durable Medical Equipment: Custom built orthopedic shoes are covered. Limited to 1 pair per Benefit Period.	90% - 10%	90% - 10%	70% - 30%
Emergency Medical Services:	90% - 10%	90% - 10%	90% - 10%
High-Tech Imaging Services: Imaging Services which include, but are not limited to, MRIs, MRAs, CT Scans, PET Scans, and nuclear cardiology.	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 a maximum of 360 visits per lifetime.	90% - 10%	90% - 10%	70% - 30%
Inpatient Hospital Admission Includes all Inpatient Hospital Facility Services.	90% - 10%	90% - 10%	70% - 30%
Low-Tech Imaging Services: Imaging Services which include, but are not limited to, x-rays, machine tests and diagnostic imaging.			
Performed within the office, clinic, or independent lab of a Network Provider.	100% Deductible Waived	100% Deductible Waived	70% - 30%
Not performed within the office, clinic, or independent lab of a Network Provider.	90% - 10%	90% - 10%	70% - 30%
Mental Health and Substance Use Disorders:			
Office Visit for Mental Health and Substance Use Disorder Benefits	\$35.00 per visit	\$45.00 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:	90% - 10%	90% - 10%	Not Covered
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 Coinsurance shown for each, if any.	90% - 10%	90% - 10%	70% - 30%
Initial Pregnancy Confirmation Office Visit:	\$35.00 per visit	\$45.00 per visit	70% - 30%

Preventive or Wellness Care: See the "Preventive or Wellness Care" Article for more details on Preventive or Wellness Care Benefits.	100% Deductible Waived	100% Deductible Waived	Not Covered
Private Duty Nursing: Benefit limited to Inpatient Services Only.	90% - 10%	90% - 10%	70% - 30%
Rehabilitative Care Services:	90% - 10%	90% - 10%	70% - 30%
Skilled Nursing Facility:	90% - 10%	90% - 10%	70% - 30%
Temporomandibular Joint (TMJ) Disorders: Benefits limited to \$600 per lifetime for Splint Therapy only and includes Panoramic x-rays.	90% - 10%	90% - 10%	70% - 30%
Travel & Lodging:	Organ Transplant lodging, meals, and transportation (combined) are covered. <ul style="list-style-type: none"> • Benefits are limited to a maximum of \$10,000 per lifetime. • \$50 per diem per day rate for patient and one (1) individual. • \$100 per diem per day rate for patient and two (2) individuals. 		
Urgent Care Center:	\$40.00 per visit	\$50.00 per visit	\$50.00 per visit
Vision Care Exam:	\$25.00 per visit	\$30.00 per visit	Not Covered
Wig after Chemotherapy: Benefit limited to 1 wig per lifetime.	90% - 10%	90% - 10%	70% - 30%

PRESCRIPTION DRUG BENEFITS

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.

CARE MANAGEMENT

Requests for Authorization must be made by calling 1-800-523-6435.

This Schedule of Benefits lists the specific services, supplies, and Prescription Drugs that require Authorization. For more information on those items and services that require Authorization visit the website, www.bcbsla.com/priorauth.

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

Authorization of services is NOT a guarantee of payment.

Authorization for Inpatient and Emergency Admissions:

Inpatient Admissions and Emergency Admissions must be Authorized. Refer to the Care Management Article and if applicable, the 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 by calling 1-800-523-6435.

If a Network Provider or a Participating 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 or Participating Provider is responsible for the penalty and all charges not covered. The Plan Participant remains responsible for any applicable cost sharing.

Benefits for Participating and Non-Participating Providers will be paid at the lower Non-Network level shown on this Schedule of Benefits.

If a Non-Participating Provider fails to obtain a required Authorization, We will reduce Allowable Charges by the penalty shown below. The Plan Participant is responsible for all charges not covered for any applicable cost sharing.

Penalty: Five Hundred Dollar (\$500.00) reduction of the Allowable Charges.

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

If a Network Provider fails to obtain a required Authorization, We will reduce Allowable Charges by the penalty stipulated in the Provider's contract. This penalty applies to all Outpatient services and supplies requiring an Authorization. The Network Provider is responsible for the penalty and all charges not covered. The Plan Participant remains responsible for any applicable cost sharing.

Benefits for Non-Network Providers will be paid at the lower Non-Network level shown on this Schedule of Benefits.

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 cost sharing.

If a Provider fails to obtain Authorization for the Outpatient services and supplies which indicate no Benefit without written / prior Authorization on the prior Authorization list, the Outpatient services and supplies are not covered.

SERVICES THAT REQUIRE AUTHORIZATION:

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 by calling 1-800-523-6435.

- Air Ambulance (Non-Emergency) (no Benefit without prior Authorization)
- Applied Behavior Analysis
- Bariatric Surgery
- Bone Growth Stimulator
- Cardiac Rehabilitation
- Cellular Immunotherapy (no Benefit without written Authorization)
- Day Rehabilitation Programs
- Durable Medical Equipment (greater than \$1,000.00)
- Electric & Custom Wheelchairs
- Food or food supplements, formulas and medical foods
- Gene Therapy (no Benefit without written Authorization)
- Genetic or Molecular Testing
- Home Health Care
- Hospice
- Hyperbarics

• Implantable Medical Devices over \$2,000.00 (including but not limited to defibrillators)
• Low Protein Food Products
• PET Scans
• Prosthetic Appliances
• Pulmonary Rehabilitation
• Surgical Treatment of Erectile Dysfunction (including penile implants)
• Transplant Evaluation & Transplants (no benefit without written Authorization)
• Vacuum Assisted Wound Closure Therapy

ELIGIBILITY WAITING PERIOD

The Plan Administrator will determine the Eligibility Waiting Period and Effective Date of coverage for all eligible Employees and their Dependents. Under no circumstances will the initial Eligibility Waiting Period ever exceed ninety (90) days following the date of hire.

Active Employee & Retirees:

Effective 05/01/25 - The Effective Date is the first day of the following month of employment.