CALCASIEU PARISH SCHOOL BOARD		
SCHEDULE OF BENEFITS		
Plan Name:		Group Number:
Calcasieu Parish School Board PPACA Option		**77376FF4**
Network:		Product Type:
Preferred Care PPO		**HDHP**
Plan's Original Benefit Date:	Plan's Amended Benefit Date:	Plan's Anniversary Date:
May 1st, 2013	**May 1st, 2024**	**May 1st**
Benefit Period:	Calendar Year - January 1 through December 31	

MEDICAL DEDUCTIBLE:		
Deductible Amounts listed apply to the 2024 Benefit Period.	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
Individual Deductible Amounts:	$5,000	$10,000
Family Deductible Amounts:	$9,000	$18,000
Special Notes:		
• This plan has a Per Member Within the Family Deductible Amount of six thousand eight hundred and fifty dollars ($6,850). No person may contribute more than six thousand eight hundred and fifty dollars ($6,850) to the Network Family Deductible Amount. • If the Benefit Plan includes more than one (1) member, the Individual Deductible Amount is not applicable and only the Family Deductible Amount applies. The Per Member Within a Family Deductible Amount will also apply to Network Providers only. No Benefits are eligible for any member of the family until the Family Deductible Amount is satisfied. • Benefits for Emergency Services from Non-Network Providers that accrue to the Deductible Amount for Non-Network Providers WILL ALSO accrue to the Deductible Amount for Network 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.		
Deductible Accrual:		
• Benefits for services of Network Providers that accrue to the Deductible Amount for Network Providers WILL NOT accrue to the Deductible Amount for Non-Network Providers. • Benefits for services of Non-Network Providers that accrue to the Deductible Amount for Non-Network Providers WILL NOT 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:		
• Preventive or Wellness Care (Network Providers)		

OUT-OF-POCKET AMOUNT:		
The Following accrue to the Out-of-Pocket Amount: Deductibles and Coinsurance.	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
Individual Out-of-Pocket Amounts:	$5,000	$10,000
Family Out-of-Pocket Amounts:	$9,000	$18,000
Special Notes:		

- This plan has a Per Member Within the Out-of-Pocket Amount of six thousand eight hundred and fifty dollars ($6,850). No person may contribute more than six thousand eight hundred and fifty dollars ($6,850) to the Network Family Out-of-Pocket Amount.
- Benefits for Emergency Medical Services of Network and Non-Network Providers WILL accrue to the Out-of-Pocket Amount for Network 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.

Out-of-Pocket Accrual:

- Benefits for services of Network Providers that accrue to the Out-of-Pocket Amount for Network Providers WILL NOT accrue to the Out-of-Pocket Amount for Non-Network Providers.
- Benefits for services of Non-Network Providers that accrue to the Out-of-Pocket Amount for Non-Network Providers WILL NOT 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 VISITS (AFTER DEDUCTIBLE):		
Coinsurance shown as Company – Plan Participant responsibility.	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
Office Visits:	100% - 0%	80% - 20%

MEDICAL BENEFITS – COINSURANCE:		
Coinsurance shown as Company – Plan Participant responsibility Deductible must be met prior to applicable Coinsurance unless stated otherwise.	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
Ambulance Services:		
Air Ambulance Services:	100% - 0%	100% - 0%
Emergency Ground Ambulance Services (In-State):	100% - 0%	80% - 20%
Emergency Ground Ambulance Services (Out-of-State):	100% - 0%	80% - 20%
Non-Emergency Ground Ambulance Services:	100% - 0%	80% - 20%
Ambulatory Surgical Center and Outpatient Surgical Facility: Includes all Surgical Professional and Physician Charges	100% - 0%	80% - 20%
Dentofacial Anomalies: Benefit limited to one thousand dollars ($1,000) per Plan Participant per lifetime.	100% - 0%	80% - 20%
Durable Medical Equipment: These services require prior authorization if greater than three hundred dollars ($300).	100% - 0%	80% - 20%

Emergency Medical Services: Performed in the Emergency Department of a Hospital. Includes Facility and Professional/Physician charges.	100% - 0%	100% - 0%
High Tech Imaging: Benefit Includes CT, MRI, MRA, PET, or Nuclear Cardiology. PET scans require prior authorization.	100% - 0%	80% - 20%
Home Health Care: These services require prior authorization.	100% - 0%	80% - 20%
Hospice Care: Bereavement Counseling services are available under Hospice Care for all covered family Members of a Plan Participant in Hospice Care prior to and within six (6) months following the Plan Participant's death. These services require prior authorization.	100% - 0%	80% - 20%
Low-Tech Imaging and Laboratory Tests: Imaging Services which include, but are not limited to, x-rays, machine tests and diagnostic imagining.	100% - 0%	80% - 20%
Inpatient Hospital Admission: Includes all Inpatient Hospital Facility Services.	100% - 0%	80% - 20%
Mental Health and Substance Use Disorders: Inpatient Services require prior authorization.	100% - 0%	80% - 20%
Organ, Tissue, and Bone Marrow Transplants: Expenses for transportation, lodging and meals for the Plan Participant and family Members are limited to a maximum amount of two hundred dollars ($200) per day up to a maximum amount of ten thousand dollars ($10,000) per year. These services require prior authorization.	100% - 0%	80% - 20%
Pregnancy Care:	100% - 0%	80% - 20%
Preventive or Wellness Care: See the "Preventive or Wellness Care" Article for more details on Preventive or Wellness Care Benefits.	100% - 0% Deductible waived	80% - 20%
Private Duty Nursing: Benefit limited to Outpatient Services only. These services require prior authorization.	100% - 0%	80% - 20%
Rehabilitative Care Services: Inpatient Admission and Day Rehabilitation programs must begin within seventy-two (72) hours following discharge from an Inpatient Hospital for the same or a similar condition. The Plan Participant must be able to tolerate a minimum of three (3) hours of active therapy per day. These services require authorization prior to admission.	100% - 0%	80% - 20%

Skilled Nursing Facility:	100% - 0%	80% - 20%
Urgent Care Center:	100% - 0%	80% - 20%

PRESCRIPTION DRUG BENEFITS:

THE FOLLOWING PHARMACY SERVICES AND CLAIMS ADMINISTRATION OF PHARMACY RELATED CLAIMS ARE PERFORMED BY EXPRESS SCRIPTS THROUGH EXPRESS SCRIPTS, NOT BLUE CROSS BLUE SHIELD OF LOUISIANA. BLUE CROSS BLUE SHIELD OF LOUISIANA IS NOT RESPONSIBLE FOR THE CONTENT OR ACCURACY OF THIS INFORMATION. ANY QUESTIONS, COMMENTS OR CONCERNS REGARDING YOUR PRESCRIPTION DRUG BENEFITS SHOULD BE ADDRESSED DIRECTLY TO EXPRESS SCRIPTS THROUGH RXBENEFITS BY CALLING 1-800-849-9065.

CARE MANAGEMENT – PRIOR AUTHORIZATIONS:

Requests for Authorization must be made to Blue Cross and Blue Shield of Louisiana by calling **1-800-523-6435.**

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” and if applicable “Pregnancy Care and Newborn Care Benefits” sections 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 or a Participating Provider fails to obtain a required Authorization, We will reduce Allowable Charges by the penalty amount stipulated in the Provider’s contract with Us or with another Blue Cross and Blue Shield plan. This penalty applies to all covered Inpatient charges. The Network Provider or Participating Provider is responsible for the penalty and all charges not covered. The Plan Participant remains responsible for his Deductible and any Coinsurance percentages.

If a Non-Participating Provider fails to obtain a required Authorization, the Plan will reduce Allowable Charges by the amount shown below. This penalty applies to all covered Inpatient charges. The Plan Participant is responsible for all charges not covered and for any applicable Deductible and Coinsurance percentage.

Additional Plan Participant responsibility if Authorization is not requested for an Inpatient Admission to a Non-Network Provider Hospital: **One thousand dollar** (**$1,000) reduction of the Allowable Charges.**

AUTHORIZATION OF OUTPATIENT SERVICES, INCLUDING OTHER COVERED SERVICES AND SUPPLIES:

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 below, the Outpatient services and supplies are not covered.

If a Network Provider or Participating provider fails to obtain a required Authorization, We will reduce the Allowable Charges by the amount shown below. This penalty applies to all 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 the applicable Deductible Amount and Coinsurance percentage.

Additional Network Provider responsibility if Authorization is not requested for Outpatient services and supplies: **Thirty percent (30%) reduction of the Allowable Charges.**

If a Non-Network Provider fails to obtain a required Authorization, Benefits will be paid at the lower Non-Network level shown on this Schedule of Benefits. The Plan Participant is responsible for all charges not covered and for any applicable Deductible Amount and Coinsurance percentage.

SERVICES THAT REQUIRE PRIOR AUTHORIZATION:
The following Outpatient services and supplies require Authorization prior to the services being rendered or supplies being received.
• Air Ambulance (Non-Emergency) (No Benefit Without Prior Authorization)
• Applied Behavior Analysis
• Bone Growth Stimulator
• Cardiac Rehabilitation
• Cellular Immunotherapy (No Benefit Without Prior Authorization)
• Day Rehabilitation Programs
• Durable Medical Equipment (Over $300)
• Electric & Custom Wheelchairs
• Gene Therapy (No Benefit Without Prior Authorization)
• Genetic or Molecular Testing
• Home Health Care
• Hospice
• Hyperbarics
• Implantable Devices over $2,000.00 (including but not limited to defibrillators)
• Infusion Therapy - includes home and facility administration (exception: not required when performed in an office, the drug to be infused may require Authorization)
• Intensive Outpatient Programs
• Low Protein Food Products
• Orthotic Devices (Over $300)
• Partial Hospitalization Programs
• PET Scans
• Private Duty Nursing
• Prosthetic Appliances
• Pulmonary Rehabilitation
• Residential Treatment Centers
• Sleep Studies, except for those performed as a home sleep study
• Surgical Treatment of Erectile Dysfunction (including penile implants)
• Transplant Evaluation & Transplants (No Benefit Without Prior 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 exceed ninety (90) days following the date of Hire.