ST. TAMMANY PARISH SCHOOL BOARD		
SCHEDULE OF BENEFITS		
PLAN NAME		**GROUP NUMBER**
St. Tammany Parish School Board – Retiree Plan		78B03ERC
PLAN'S ORIGINAL BENEFIT PLAN DATE	**PLAN'S AMENDED BENEFIT PLAN DATE**	**PLAN'S ANNIVERSARY DATE**
January 1, 2007	January 1, 2019	January 1st

BENEFIT PERIOD:	Calendar Year - January 1 through December 31

DEDUCTIBLE:	
	ALL PROVIDERS
Individual Deductible Amount:	$500
Family Deductible Amount:	$1,000

SPECIAL NOTES:

The Deductible Amount is a single amount that includes eligible charges incurred from all Providers combined.

A Plan Participant does not have to meet the Individual Benefit Period Deductible Amount to be eligible for the Family Deductible Amount.

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 age 17 and under (All Providers)
- Pre-Admission Testing (Network)
- Preventive or Wellness Care (Network)

OUT-OF-POCKET AMOUNT – Includes the Deductible, Coinsurance and Copayments.	
All Other Providers –	
Individual:	$2,750
Family:	$5,500

SPECIAL NOTES:

The Out-of-Pocket Amount is a single amount that includes eligible charges incurred from all Providers combined.

MEDICAL BENEFITS – COPAYMENTS AND COINSURANCE:		
	NETWORK	**NON-NETWORK**
Coinsurance shown as Company - Plan Participant responsibility.		
Copayments shown are the Plan Participant responsibility.		
Inpatient and Outpatient Facility and Professional Services for Which a Copayment is not Applicable:	90% - 10%	70% - 30%
Primary Care Office Visits for the following Providers:	$30 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:	$45 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%	70% - 30%
Emergency Ambulance Services:	90% - 10%	90% - 10%
Ambulatory Surgical Center and Outpatient Surgical Facility: Includes Facility and Professional / Physician Services.	90% - 10%	70% - 30%
Emergency Medical Services – performed in the Emergency Department of a Hospital: Includes Facility and Professional/Physician Services.	90% - 10%	90% - 10%
Non-Emergency Medical Services – performed in the Emergency Department of a Hospital: Includes Facility and Professional/Physician Services.	90% - 10%	70% - 30%
Home Health Care: Limited to 150 visits per Plan Participant each Benefit Period.	90% - 10%	70% - 30%

Hospice Care: Limited to 360 days (Inpatient and Outpatient combined) per Plan Participant per Lifetime.	90% - 10%	70% - 30%
Mental Health and Substance Use Disorder:		
Office Visit for Mental Health and Substance Use Disorder Benefits	$45 Copayment per visit	70% - 30%
Outpatient Mental Health and Substance Use Disorder Benefits (Includes Office Visits, Outpatient Facility and Outpatient Therapies)	100% Deductible Waived	70% - 30%
Inpatient Mental Health and Substance Use Disorder Benefits (Includes Facility and Professional/Physician Services)	90% - 10%	70% - 30%
Organ, Tissue, and Bone Marrow Transplants: • Authorization required prior to services being performed. • Lodging, Meals and Transportation Benefits limited to: o $10,000 per Participant per Lifetime o $50 per diem rate for patient and one (1) individual o $100 per diem rate for patient and two (2) individuals	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%	70% - 30%
Pre-Admission Testing:	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.	$45 Copayment per pregnancy	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	Not Covered
Private Duty Nursing: • Inpatient Services Only. • Limited as specified by the Plan.	90% - 10%	70% - 30%
X-rays, Lab Tests, Machine Tests, and High-Tech Imaging:		
X-Rays, Lab Tests and Machine Tests –	90% - 10%	70% - 30%
Performed within the office or clinic of a Network Provider that is subject to the Office Visit Copayment.	100% Deductible Waived	70% - 30%
Performed within a Network Independent Lab.	90% - 10%	70% - 30%
High-Tech Imaging – such as CT, MRI, MRA, PET Scans or Nuclear Cardiology.	90% - 10%	70% - 30%
Rehabilitative Care Services:		
• Physical Therapy and Occupational Therapy	90% - 10%	70% - 30%
• Speech Therapy, including developmental Speech Therapy	90% - 10%	70% - 30%
• Chiropractic Services	90% - 10%	70% - 30%

Skilled Nursing Facility: Available within 14 days of a 3 day hospital stay.	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%	70% - 30%
Urgent Care Center:	$50 Copayment per visit	$50 per visit
Vision Care Exam: Limited to one (1) exam, including refractions, per Plan Participant each Benefit Period.	$30 Copayment	Not Covered
Wig after Chemotherapy: Limited to one (1) wig per Plan Participant per Lifetime.	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 FOLLOWING CATEGORIES OF PRESCRIPTION DRUGS REQUIRE PRIOR AUTHORIZATION. 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.

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 must be Authorized. Refer to "Care Management" and if applicable "Pregnancy Care and Newborn Care Benefits" sections of the Benefit Plan for complete information.

If a Network 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 is responsible for the penalty and all charges not covered. The Plan Participant remains responsible for the applicable Deductible Amount and Coinsurance percentage.

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

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

Authorization of Outpatient Services and Supplies:

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

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 the applicable Deductible Amount and Coinsurance percentage.
The following services and supplies require Authorization prior to the services being rendered or supplies being received. Request for Authorization must be made to Blue Cross Blue Shield of Louisiana by calling 1-800-376-7973.
• Air Ambulance (Non-Emergency)
• Applied Behavior Analysis
• Bone growth stimulator
• CT Scans
• Day Rehabilitation Programs
• Durable Medical Equipment (Greater than $1,000.00)
• Electric & Custom Wheelchairs
• Food or food supplements, formulas and medical foods
• Home Health Care
• Hospice
• Hyperbarics
• Implantable Medical Devices over $2000.00, such as Implantable Defibrillator and Insulin Pump
• MRI/MRA
• Nuclear Cardiology
• PET Scans
• Prosthetic Appliances
• Sleep Studies, except those performed as a home sleep study
• Skilled Nursing Facility
• Transplant Evaluation & Transplants
• Specialty Pharmacy

ELIGIBILITY WAITING PERIOD
The Plan Administrator will determine the Eligibility Waiting Period and Effective Date of coverage for all eligible Employees and their Dependents.
Retirees: Eligible Persons who satisfy the Eligibility requirement as specified by the Plan and who are eligible to participate in the Group's health care benefit plan.
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.