



**SCHEDULE OF BENEFITS  
HMO POINT OF SERVICE  
CONTRACT 13100 01140 0106**

**GROUP NAME**

East Baton Rouge Parish School System (EBRPSS)

**GROUP NUMBER**

77749 and Departments (Buy Up Plan)

**GROUP'S ORIGINAL CONTRACT DATE**

January 1, 2006

**GROUP'S ANNIVERSARY DATE**

January 1<sup>st</sup>

**GROUP'S AMENDED CONTRACT DATE**

Not Applicable

**SCHEDULE OF BENEFITS**

Lifetime Maximum Benefit	\$2,000,000.00
Benefit Period	Calendar Year for all providers

**COPAYMENTS AND COINSURANCE**

	<b>NETWORK</b>	<b>NON-NETWORK</b>	<b>DEPENDENT OUT-OF-AREA</b>
	Coinsurance shown as Group - Member responsibility Copayments shown are the Member's responsibility		
Outpatient visits for the following services:	\$20.00 per visit	70% - 30%	\$20.00 per visit
<ul style="list-style-type: none"> <li>• Primary Care Physician's office visits for the following Physician and/or Provider specialties:               <ul style="list-style-type: none"> <li>• General Practice</li> <li>• Family Practice</li> <li>• Pediatrics</li> <li>• Internal Medicine</li> <li>• OB/GYN</li> <li>• Licensed Professional Counselor</li> <li>• Masters of Social Work</li> <li>• Physiotherapists</li> <li>• Psychiatrists</li> <li>• Psychologist</li> <li>• Substance Abuse Counselor</li> <li>• Chiropractor</li> </ul> </li> </ul>			

<ul style="list-style-type: none"> <li>Speech Therapy, Physical Therapy, Occupational Therapy, Cardiac Rehabilitation</li> </ul>	90% - 10%	70% - 30%	90% - 10%
<ul style="list-style-type: none"> <li>Preventive and Wellness Care</li> </ul>	\$20.00 for Primary Care Physicians \$40.00 for Specialists	70% - 30% after Deductible	\$20.00 for Primary Care Physicians \$40.00 for Specialists
Outpatient visits for Specialists and Allied Health Professionals office visits for providers not included above	\$40.00 per visit	70% - 30%	\$40.00 per visit
Vision Care Exam, limited to 1 exam in a 24 month period (Optometrist only).	\$20.00 per visit	\$30.00 per visit	\$20.00 per visit
Emergency Room or Out-of-Service Area Emergency	90% - 10%	70% - 30%	90% - 10%
Spinal Manipulative Therapy	\$40.00 per visit	\$30.00 maximum per visit up to 20 visits each Benefit Period	\$40.00 per visit
Ambulance Services	90% - 10%	70% - 30%	90% - 10%
Ambulatory Surgical Facility	\$100.00 per surgical visit	70% - 30%	\$100.00 per surgical visit
Inpatient Hospital Admission, all Inpatient Hospital services included except Mental Disorders, Alcohol and/or Drug Abuse Admissions.	\$300.00 per Admission then 90% - 10%	70% - 30%	\$300.00 per Admission then 90% - 10%
Mental Disorders, Alcohol and/or Drug Abuse Admissions  (Copayment is in addition to the Deductible Amount and the Deductible Amount is not reduced by the Copayment.)	\$250.00 per Admission then 90% - 10%		\$250.00 per Admission then 90% - 10%
Physician's services for Pregnancy Care	\$25.00 initial visit	70% - 30%	\$25.00 initial visit
Durable Medical Equipment, Prosthetic Appliances and Orthotic Devices	80% - 20%	70% - 30%	80% - 20%

Pre-Admission Diagnostic Testing Services	100% - 0%	100% - 0%	100% - 0%
Inpatient and Outpatient services for which a Copayment is not applicable (except Inpatient Medical Services listed in Article IV, B.)	90% - 10%	70% - 30%	90% - 10%
Services for: <ul style="list-style-type: none"> <li>Home Health Care, (limited to 75 visits each Benefit Period)</li> <li>Hospice Care, (limited to 180 days Lifetime Maximum)</li> <li>Skilled Nursing Facility, (limited to 60 days each Benefit Period)</li> </ul>	90% - 10%	70% - 30%	90% - 10%
All other services	90% - 10%	70% - 30%	90% - 10%

## MENTAL DISORDERS, ALCOHOL AND/OR DRUG ABUSE

### NETWORK, NON-NETWORK AND DEPENDENT OUT-OF-AREA SERVICES

**Coinsurance and Inpatient Hospital Copayments for Mental Disorders, Alcohol and/or Drug Abuse are the same as for any other illness except for the following:**

- The Member's Coinsurance for Mental Disorders, Alcohol and/or Drug Abuse is **eligible** for satisfying the Out-of-Pocket Amount.

	NETWORK	NON-NETWORK	DEPENDENT OUT-OF-AREA
Copayment or Coinsurance for Physician's office visit for Mental Disorders, Alcohol and/or Drug Abuse	\$20.00 per visit; then 100% - 0%	50% - 50%	\$20.00 per visit; then 100% - 0%

### INPATIENT SERVICES

### MAXIMUM

Mental Disorders, Alcohol and/or Drug Abuse (Aggregate)

45 days each Benefit Period  
Benefits paid will accrue to the Maximum Lifetime Benefit

### OUTPATIENT SERVICES

### MAXIMUM

Mental Disorders, Alcohol and/or Drug Abuse (Aggregate)

52 visits each Benefit Period  
Benefits paid will accrue to the Maximum Lifetime Benefit

Maximums for In-Network, Non-Network and Dependent Out-Of-Area Providers will apply toward each other's maximum.

**DEDUCTIBLE/OUT-OF-POCKET AMOUNT**

	<b>NETWORK</b>	<b>NON-NETWORK</b>	<b>DEPENDENT OUT-OF-AREA</b>
<b>Benefit Period Deductible Amount</b>	\$300.00	\$1,000.00	\$300.00
The Deductible Amount incurred for each Provider <b>is not</b> eligible for satisfying the Deductible amount for the other Provider.			
<b>Out-Of-Pocket Amount</b>	\$1,700.00	\$5,750.00	\$1,700.00
Remaining Coinsurance incurred for Durable Medical Equipment, Prosthetic Appliances and Orthotic Devices provided by a Non-Network Provider is not eligible for satisfying the Out-Of-Pocket Amount.			
The Out-Of-Pocket Amount incurred for each Provider <b>is not</b> eligible for satisfying the Out-Of-Pocket Amount for the other Provider.			
<b>Family Out-Of-Pocket Amount [Aggregate]</b>	\$3,400.00	\$11,500.00	\$3,400.00
The Out-Of-Pocket Amount incurred for each Provider <b>is not</b> eligible for satisfying the Out-Of-Pocket Amount for the other Provider.			

**ORGAN, TISSUE AND BONE MARROW TRANSPLANTS**

- Benefits are subject to applicable Deductible, Coinsurance, Inpatient and Outpatient Copayments.
- Organ, tissue and bone marrow transplants and evaluation for a Member’s suitability for organ, tissue and bone marrow transplants will not be covered unless a Member obtains written Authorization from Us prior to services being rendered.
- Acquisition Expense Maximum accrues to the Lifetime Maximum Benefit.
- Organ, Tissue and Bone Marrow Transplant Maximum accrues to the Lifetime Maximum Benefit.
- Non-Network Benefits are not available for Organ, Tissue and Bone Marrow Transplants.

	<b>NETWORK</b>	<b>DEPENDENT OUT-OF-AREA</b>
Organ, Tissue Bone Marrow Transplant Maximum	Same as for any other illness	Same as for any other illness
Acquisition Expense Maximum	Same as for any other illness	Same as for any other illness

**PRIVATE DUTY NURSING**

Outpatient Private Duty Nursing services are limited to a Benefit Period maximum of ninety (90) shifts (eight (8) hours per shift) for each member.

---

---

## **AUTHORIZATION OF ADMISSIONS**

- **All Admissions must be Authorized to receive Benefits. If Authorization is not requested within the time frame specified in the Benefit Plan, Benefits will be reduced by fifty percent (50%) of the Allowable Charge.**
- **If Authorization of an Admission is not requested, the Member's claim may be reviewed for Medical Necessity. If it is determined that the Admission is not Medically Necessary, the Admission will not be covered and the Member must pay all charges. If the Admission is not requested within the time frame specified in the Benefit Plan, Benefits will be reduced by fifty percent (50%) of the Allowable Charge.**
- **Requests for Authorization of all Admissions and for Concurrent Review of an Admission in progress must be made to HMO Louisiana, Inc. by calling 1-800-376-7973.**
- **If a request for Authorization or Concurrent Review is denied, the Admission will not be covered.**

---

---

## **AUTHORIZATION FOR OUTPATIENT SERVICES AND SUPPLIES**

The following Outpatient services and supplies require Authorization prior to services being rendered to receive Network Benefits. Authorization is not required for Dependent Out-of-Area Benefits.

- **Requests for Authorization must be made to HMO Louisiana, Inc. by calling 1-800-376-7973.**
- Refer to the "Authorization of Services" section in this Contract for complete information.
  - Alcohol and Drug Services
  - Cardiac Rehabilitation
  - Durable Medical Equipment (greater than \$200.00)
  - Home Health Care
  - Hospice Care
  - Mental Health Services
  - Non-Emergency Ambulance
  - Occupational Therapy
  - Orthotic Devices
  - All outpatient surgical procedures not performed in a Physician's office
  - 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

## 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 ‘Limitations And Exclusions’. A Member may receive credit toward this exclusionary period for any time he served toward a Pre-Existing Conditions exclusionary period under his prior coverage. See the Benefit Plan for complete details.

---

---