

**ASO COMPREHENSIVE MEDICAL BENEFIT PLAN
(40XX1354 01/06)
SCHEDULE OF BENEFITS**

GROUP NAME

GROUP NUMBER

East Baton Rouge Parish School System

77749 (PPO Core Plan)

**GROUP'S ORIGINAL
EFFECTIVE DATE**

**GROUP'S AMENDED
BENEFIT PLAN DATE**

**GROUP'S ANNIVERSARY
DATE**

January 1, 2006

Not Applicable

January 1st

Lifetime Maximum:

\$2,000,000.00 per Member.

Benefit Period Deductible Amount (Individual):

PPO Preferred Providers

\$500.00

All Other Providers

\$1,500.00

The Deductible Amount incurred all Other Providers is eligible for satisfying the Deductible Amount for Preferred Providers.

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

Pre-Admission Testing & Diagnostic Services

Eligible Vision Care Services

Coinsurance:

PPO Preferred Providers of the Preferred Care Network

Group

Member

80%

20%

All other Providers

60%

40%

Special Coinsurance:

Pre-Admission Diagnostic Testing Services

100%

0%

Special Notes:

Benefits will be provided at one hundred percent (100%) of the Allowable Charge if a Copayment has been applied for Outpatient services.

Benefits will be provided at eighty percent (80%) of the Allowable Charge if a Copayment has been applied for Inpatient services.

Benefits will be provided at eighty percent (80%) of the Allowable Charge if a Deductible has been applied until the Out-of-Pocket Amount has been reached. Thereafter, Benefits will be provided at one hundred percent (100%) of the Allowable Charge for the remainder of the Benefit Period for each Member.

A reduction in Benefits will be applied for using a Nonparticipating Provider Hospital as described in the Introduction section of the Benefit Plan.

Out-of-Pocket Amount - Does NOT include the Deductible Amount or Copayments:

Individual	
Preferred Providers	\$2,500.00
All Other Providers:	\$5,750.00
Family	
PPO Preferred Providers	\$5,000.00
All Other Providers	\$11,500.00

Special Notes:

The Out-of-Pocket Amount incurred for all Other Providers **is** eligible for satisfying the Out-of-Pocket Amount for Preferred Providers.

When services are performed by other than a Preferred Provider, the remaining Coinsurance for Durable Medical Equipment, Orthotic Devices and Prosthetic Appliances **is not** eligible for satisfying the Out-of-Pocket Amount.

Physician’s Office Visit Copayment: \$25.00 per visit for Primary Providers
 (Services must be provided by one of the following) \$50.00 per visit for all other Providers

Primary Care Physician’s office visits for the following Physician and/or Provider specialties:

- General Practice
- Family Practice
- Pediatrics
- Internal Medicine
- OB/GYN
- Licensed Professional Counselor
- Masters of Social Work
- Physiotherapists
- Psychiatrists
- Psychologist
- Substance Abuse Counselor
- Chiropractor

Inpatient Facility Copayment (Preferred Providers) \$200.00 for each Admission
 (All services except for Mental Disorders, Alcohol and/or Drug Abuse)

Inpatient Facility Copayment (Preferred Providers) \$250.00 for each Admission
 (Mental Disorders, Alcohol and/or Drug Abuse)

The above Copayment Amounts are in addition to the Benefit Period Deductible Amount and the Benefit Period Deductible Amount is not reduced by these Copayment Amounts.

Pregnancy Care Copayment (Preferred Providers only): \$25.00 initial visit
 All Benefits for maternity and/or Pregnancy Care services are subject to other limitations stated in the Benefit Plan.

Vision Care Copayment: \$25.00 per visit (Preferred Providers)
 (Optometrist only) \$30.00 per visit (all other Providers)

Spinal Manipulative Therapy:
 Preferred Providers: \$50.00 per visit (then 100%/0%)
 All Other Providers: \$30.00 maximum per visit
 Up to twenty (20) visits each Benefit Period.

Skilled Nursing Facility:
 Benefits are limited to a Benefit Period maximum of sixty (60) days for each Member.

Home Health Care:
 Benefits are limited to a Benefit Period maximum of seventy-five (75) visits for each Member.

Hospice Care:
 Benefits are limited to a lifetime maximum of one hundred eighty (180) days for each Member.

Private Duty Nursing Services: (Authorization is required prior to services being performed)
 Outpatient services are limited to a Benefit Period maximum of ninety (90) shifts (eight (8) hours per shift) for each Member.

Preventive or Wellness Care:
 Preferred Providers (Deductible Amount does not apply): \$25.00 per visit (then 100%/0%)
 All Other Providers: Subject to Deductible Amount and Applicable Coinsurance

Organ, Tissue, and Bone Marrow Transplant Benefits (Authorization required prior to services being performed):

Lifetime Maximum for all covered transplants combined: None
 Benefits paid will accrue to the overall Lifetime Maximum Benefit shown above

Acquisition Expense Maximum per covered transplant: None
 Benefits paid will accrue to the overall Lifetime Maximum Benefit shown above

Mental Disorders, Alcohol and/or Drug Abuse:

	<u>Group</u>	<u>Member</u>
Coinsurance - Inpatient		
PPO Preferred Providers (after Deductible and Copayment)	80%	20%
All Other Providers	60%	40%

Coinsurance – Outpatient		
PPO Preferred Providers (after \$25.00 Copayment per visit)	100%	0%
All other Providers	50%	50%

Member's remaining Coinsurance **is eligible** for satisfying the Out-of-Pocket Amount.

Benefit Period Maximum

Inpatient	45 days for each Member
Outpatient	52 visits for each Member

The maximums incurred for one type of Provider will apply toward the maximums incurred for the other type of Provider.

Rehabilitative Care Services:

Physical Therapy, Occupational Therapy, and/or Speech Language/Pathology Therapy is covered the same as any other illness under this Benefit Plan for each Member. No maximums are applicable.

AUTHORIZATION OF SERVICES AND SUPPLIES

Authorization of Inpatient and Emergency Admissions:

Inpatient Admissions must be Authorized. Refer to “Authorization of Services and Supplies” and if applicable “Pregnancy Care Benefits” sections of the Benefit Plan for complete information. Requests for Authorization of Inpatient Admissions, for Concurrent Review of an Admission in progress, or other Covered Services and supplies must be made to Blue Cross and Blue Shield of Louisiana by calling 1-800-392-4076.

Benefits will be reduced by fifty percent (50%) of the Allowable Charge if Authorization of an Inpatient Admission is not requested.

Authorization of Other Covered Services and Supplies:

The following services and supplies require Authorization prior to the services being rendered or supplies being received.

- 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

Refer to the “Authorization of Services and Supplies, and if applicable, Pregnancy Care Benefits section of the Benefit Plan for complete information.

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 the “Limitations and Exclusions” article of the Benefit Plan. A Member may receive credit toward this exclusionary period for any time he served toward a Pre-Existing Condition Exclusion Period under his prior coverage.