Terrebonne General Health System			
SCHEDULE OF BENEFITS			
EMPLOYER PREFERED OPTION			
Plan Name:			**Group Number:**
Terrebonne General Health System			78T07ERC
Network:			**Plan Type:**
Preferred Care PPO			PPO- Plan B
Plan's Original Benefit Date:	**Plan's Amended Benefit Date:**		**Plan's Anniversary Date:**
January 1, 2022	January 1, 2023		January 1st
Benefit Period:		Calendar Year - January 1 through December 31	
EPO Provider:		Terrebonne General Health System	

MEDICAL DEDUCTIBLE:			
Deductible Amounts listed apply to the 2023 Benefit Period.	**EPO PROVIDERS**	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
Individual Deductible Amounts:	$2,000.00	$2,500.00	$3,000.00
Family Deductible Amounts:	$4,000.00	$5,000.00	$6,000.00

Special Notes:

- 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.

Deductible Accrual:

- Benefits for services of an EPO Provider that accrue to the Deductible and/or the Out-of-Pocket Amount for EPO Providers **WILL** accrue to the Deductible and/or the Out-of-Pocket Amount for Network Providers.
- Benefits for services of Network Providers that accrue to the Deductible and/or the Out-of-Pocket Amount for Network Providers **WILL** accrue to the Out-of-Pocket Amount for EPO Providers.
- Benefits for services of Non-Network Providers that accrue to the Deductible and/or the Out-of-Pocket Amount for Non-Network Providers **WILL NOT** accrue to the Deductible and/or the Out-of-Pocket Amount for EPO and Network Providers.
- Benefits for Emergency Medical Services of Non-Network Providers **WILL** accrue to the Deductible Amount for Network Providers.
- Benefits for Non-Emergency Services performed by a 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:

- Eligible Preventive/Wellness Care services, EPO/Network Providers
- Emergency Medical Services, EPO Providers only
- Outpatient Facility High Tech Imaging Services, EPO Providers only
- Outpatient Facility Low Tech Imaging, EPO Providers only

OUT-OF-POCKET AMOUNT:			
The Following accrue to the Out-of-Pocket Amounts: Copayments, Deductibles, and Coinsurance.	**EPO PROVIDERS**	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
Individual Out-of-Pocket Amounts:	$5,000.00	$6,000.00	Unlimited per person
Family Out-of-Pocket Amounts:	$10,000.00	$12,000.00	Unlimited per person

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.

Out-of-Pocket Accrual:

- Benefits for services of an EPO Provider that accrue to the Deductible and/or the Out-of-Pocket Amount for EPO Providers **WILL** accrue to the Deductible and/or the Out-of-Pocket Amount for Network Providers.
- Benefits for services of a Network Providers that accrue to the Out-of-Pocket Amount for Network Providers **WILL** 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 Emergency Medical Services of Non-Network Providers **WILL** accrue to the Out-of-Pocket Amount for Network Providers.
- Benefits for Non-Emergency Services performed by Non-Network Provides at Network facilities Will accrue to the Out-of-Pocket Amount for Network Providers.

MEDICAL BENEFITS – COINSURANCE:			
Coinsurance shown as Company – Plan Participant responsibility.	**EPO PROVIDERS**	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
Ambulance Services:	See Below	See Below	See Below
Air Ambulance Services:	Deductible then 90% - 10%	Deductible then 70% - 30%	Deductible then 70% - 30%
Ground Ambulance Services:	Deductible then 90% - 10%	Deductible then 70% - 30%	Deductible then 30% - 70%
Ambulatory Surgical Center and Outpatient Surgical Facility: Includes all Surgical Professional and Physician Charges	Deductible then 90% - 10%	$1,000 Copayment/$1,500 Copayment then30% Coinsurance after deductible	$1,500 Copayment then 70% Coinsurance after deductible
Dietitian Visits:	Deductible then 90% - 10%	Deductible then 70% - 30%	Deductible then 30% - 70%
Emergency Medical Services: Performed in the Emergency Department of a Hospital. Includes Hospital facility charge and Professional/Physician charges.	$150 Copayment per visit then 100% deductible waived	Deductible then 70% - 30%	Deductible then 70% - 30%
Professional/Physician Charges	Deductible then 90%-10%	Deductible then 70% - 30%	Deductible then 70% - 30%

High-Tech Imaging: Imaging Services which include, but are not limited to CT scans, MRIs, MRAs, PET scans, or Nuclear Cardiology.	Outpatient facility100% Deductible Waived	Deductible then 70% - 30%	Deductible then 30% - 70%
Home Health Care: Limited to 40 visits per Benefit Period	Deductible then 90% - 10%	Deductible then 70% - 30%	Deductible then 30% - 70%
Hospice Care:	Deductible then 90% - 10%	Deductible then 70% - 30%	Deductible then 30% - 70%
Inpatient Hospital Admission: Includes all Inpatient Hospital Facility Services.	Deductible then 90% - 10%	$1000 Copayment/ $1,500 Copayment then 30% Coinsurance after deductible	$1500 Copayment then 70% Coinsurance after the deductible
Low-Tech Imaging Imaging Services which include, but are not limited to x-rays, machine tests, diagnostic imaging and radiation therapy.	100% Deductible Waived	Deductible then 70% - 30%	Deductible then 30% - 70%
Mental Health and Substance Use Disorders:	Deductible then 90% - 10%	Deductible then 70% - 30%	Deductible then 30% - 70%
Inpatient:	Deductible then 90% - 10%	$1,000 Copayment / $1,500 Copayment then 30% Coinsurance after deductible	$1,500 Copayment then 70% Coinsurance after deductible
Organ, Tissue, and Bone Marrow Transplants:	Deductible then 90% - 10%	Deductible then 70% - 30%	Deductible then 30% - 70%
Preventive or Wellness Care: See the “Preventive or Wellness Care” Article for more details on Preventive or Wellness Care Benefits.	100%	100%	Deductible then 30% - 70%
Private Duty Nursing: Benefit limited to Outpatient Services only. Benefit Limited to: Maximum of 400 hours per benefit period, all providers combined.	Deductible then 90% - 10%	Deductible then 70% - 30%	Deductible then 30% - 70%
Rehabilitative Care Services: Physical and occupational therapy have a combined 30 visit limit; applies to in network and out of network. EPO network is unlimited. Chiropractic visit limit per benefit period is 52.	Deductible then 90% - 10%	Deductible then 70% - 30%	Deductible then 30% - 70%
Skilled Nursing Facility: Limited to 90 visits per benefit period.	Deductible then 90% - 10%	Deductible then 70% - 30%	Deductible then 30% - 70%
Urgent Care Center:	Deductible then 90% - 10%	Deductible then 70% - 30%	Deductible then 30% - 70%

CARE MANAGEMENT:

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 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 services is NOT a guarantee of payment. Penalty amounts are considered non-covered and will not accrue to the Out-of-Pocket Amount.

Authorization for Inpatient and Emergency Admissions:

Inpatient Admissions and Emergency Admissions must be Authorized. Refer to 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 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. The Network Provider or Participating Provider is responsible for the penalty and all charges not covered. The Plan Participant remains responsible for any applicable Copayment or his Deductible Amount and Coinsurance .

NOTE: Benefits for 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, the Plan will reduce Allowable Charges by the amount shown below. The Plan Participant is responsible for all charges not covered and for any applicable Copayments, Deductible and Coinsurance percentage.

Twenty percent (20%) 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 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.

Thirty percent (30%) reduction of the Allowable Charges.

If a Non-Network Provider fails to obtain a required Authorization, We will reduce Allowable Charges by the amount shown below. This penalty applies to all services and supplies requiring an Authorization. The Plan Participant is responsible for all charges not covered and for any applicable Deductible 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 and Ground Ambulance (Non-Emergency) (No Benefit Without Prior Authorization)
- Applied Behavior Analysis
- Bone Growth Stimulator
- Cardiac Rehabilitation
- Cellular Immunotherapy
- Day Rehabilitation Programs Optional Rehabilitation)
- Durable Medical Equipment (Greater than $300.00)
- Electric & Custom Wheelchairs
- Gene Therapy
- Home Health Care
- Hospice
- Hyperbarics
- Implantable Medical Devices over $2,000.00 (including but not limited to defibrillators)
- Infusion Therapy
- Intensive Outpatient Programs
- Low Protein Foods
- Oral Surgery (not required when performed in a Physician Office)
- Partial Hospitalization Programs
- Private Duty Nursing
- Prosthetic Appliances
- Pulmonary Rehabilitation
- Residential Treatment Centers
- Sleep Studies, except those performed as a home sleep study
- Temporomandibular Joint Dysfunction (TMJ) Surgical Treatment
- Transplant Evaluation & Transplants
- 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: The eligibility date is the first day of the month following 30 days of the date the employee becomes eligible.

Rehire: Employees rehired within 6 months of termination are eligible for coverage the 1st of the month following date of hire.