SCHEDULE OF BENEFITS

Health Plan
Group Care

Group Number:	**78791ERC 0000**	**Group's Anniversary Date:**	**01/01**
Group's Original Effective Date:	**01/01/2010**	**Group's Amended Effective Date:**	**01/01/2010**
Group's Name:	**SALUS SOLUTIONS LLC**		

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SUMMARY OF BENEFITS

Benefit Plan Form Number 40XX0492 R01/10

Lifetime Maximum.....$5,000,000

Deductible Amount
- Benefit Period Deductible Amount.....$1,000

Family Deductible
- Maximum aggregate deductible amount each benefit period for a class of coverage with more than one member.....$3,000

- The benefit period deductible is not applicable for eligible copayment services performed by a Physician or Optometrist.

Copayment.....$40

Coinsurance Company/Member
- Preferred Providers.....80%/20%
- Participating Providers.....60%/40%
- Nonparticipating Providers.....60%/40%
  - A reduction in benefits will be applied for using a Nonparticipating Provider Hospital as described in the Introduction section of the Benefit Plan.
- Private Duty Nursing Services.....80%/20%

Out-Of-Pocket Amount
- Each Member.....$3,000
- Maximum Out-Of-Pocket Amount For A Class Of Coverage With More Than One Member.....$6,000

Private Duty Nursing Services
- Authorization is required prior to the services being performed.
- Outpatient Maximum Amount Each Benefit Period.....$5,000

Durable Medical Equipment, Orthotic Devices, and Non-Limb Prosthetic Appliances and Devices
Aggregate Benefit Period Maximum $15,000

Prosthetic Appliances and Devices of the Limb and Prosthetic Services of the Limb
Maximum Benefit per Limb per Year $50,000

Autism Spectrum Disorders
ASD Benefit Period Maximum (until 17th birthday.) $36,000
ASD Benefit Period Maximum (age 17 and older) $10,000
ASD Lifetime Maximum.....$144,000

Continued....

Dietician Visits:
Benefits are limited to a maximum of $250 in Allowable Charges per Benefit Period for each Member.

Organ, Tissue And Bone Marrow Transplant Benefits
- Authorization is required prior to the services being performed.
- Lifetime Maximum For All Covered Transplants Combined.....None, benefits paid will accrue to the lifetime maximum shown above.
- Acquisition Expense Maximum Per Covered Transplant.....$50,000

Mental Disorders
- Benefits payable same as any other illness

Alcohol and/or Drug Abuse
- Benefits payable same as any other illness

Rehabilitative Care Benefits
- Speech/Language Pathology Therapy are limited to $2,500 in allowable charges per Benefit Period for each member

- Physical Therapy and Occupational Therapy have a combined limit of $4,500 in Allowable Charges per Benefit Period for each member

Maternity and/or Pregnancy Benefits are available under this Benefit Plan. Any limitations stated are applicable.

Accidental Injury Benefit
Maximum payment Per Member Per Benefit Period.....$350

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 1-800-523-6435.

- Additional member responsibility if Authorization is not requested: $1,000.00.

Authorization of Outpatient Services, Including Other Covered Services and Supplies

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

Continued....

- Bone Growth Stimulator
- CT Scans
- Day Rehabilitation Programs
- Electric & Custom Wheelchairs
- Home Health Care
- Hospice Care
- Hyperbarics
- Implantable Medical Devices Over $2000.00 Such As Implantable Defibrillator And Insulin Pump
- M.R.I./M.R.A.
- Non-Emergency Air Ambulance
- Nuclear Cardiology
- PET/SPECT Scans
- Prosthetic Appliances
- Sleep Studies
- Stereotactic Radiosurgery, including but not limited to Gamma Knife and Cyberknife Procedures
- Vacuum Assisted Wound Closure Therapy
- Applied Behavior Analysis

If Authorization is not requested prior to a listed service being rendered or a listed supply being received, We will have the right to determine if the service or supply was Medically Necessary. If the service or supply was Medically Necessary, Benefits will be provided based on the participating status of the Provider of the service or supply. If a contracted Provider in Louisiana's Preferred Care (or PCare) Network fails to obtain a required Authorization, we will reduce his Benefit payment by thirty percent (30%) of the Allowable Charge. This penalty applies to all services and supplies requiring an Authorization, other than Inpatient charges. The Preferred Care Provider is responsible for all charges not covered and for the penalty amount. The Member remains responsible for his Copayment, Deductible amount and applicable Coinsurance percentage. If a service or supply was not Medically Necessary, the service or supply is not covered.

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

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 CONDITION EXCLUSION PERIOD UNDER HIS PRIOR COVERAGE. SEE THE BENEFIT PLAN FOR COMPLETE DETAILS.**

ELIGIBILITY WAITING PERIODS

The eligibility date is the first billing date on or after date of employment.

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BY ACCEPTING BENEFITS UNDER THIS BENEFIT PLAN, GROUP/POLICYHOLDER AGREES TO THE FOLLOWING:

1. **It is agreed that the Group will maintain standard percentage of enrollment seventy-five percent (75%) of all eligible employees, unless the Company's records designate otherwise. The Company reserves the right to terminate the Group when participation is less than two (2) employees. In cases where there is only one (1) employee (or owner, if covered) employed by the Group, termination will be effective on the Group's next anniversary date. A Group terminated for these reasons will be given sixty (60) days written notification prior to termination.**

2. **It is agreed that new employees will apply for coverage immediately upon hire, to be effective according to the eligibility requirements as stated in the Eligibility section of this Schedule of Benefits, with the employer paying a minimum of fifty percent (50%) of each employee premium, unless the Company's records designate otherwise.**

3. **New employees who do not exercise the option to enroll themselves or their eligible Dependents during their initial period of eligibility will be subject to the eligibility requirements as stated in the Eligibility section of the Benefit Plan.**

4. **It is agreed that the Effective Date of the Benefit Plan and of an employee's coverage are subject to the approval of Our home office.**

5. **It is agreed that Blue Cross and Blue Shield of Louisiana and its subsidiaries will be the exclusively endorsed carriers for selected coverage(s).**

6. **All Employees in the Group are full-time thirty (30) hours per week minimum unless the Company's records designate otherwise.**

7. **The Group will notify Our Membership & Billing Department of a Member's termination of coverage within thirty (30) days of the date in which the Member is terminated from the Group. Company is under no obligation to refund any premium paid by Group or any Member, if payment was made to Company due to Group's failure to timely notify Company of a Member's termination of coverage.**

8. **The Group will submit to Our Membership & Billing Department evidence of a Member's election of any applicable COBRA or other continuation of coverage following such termination within three (3) business days of the Group's receipt of signed continuation forms from the Member.**

9. **The Group was offered: (1) coverage the same as any other illness for: (a) Mental Disorders and (b) alcohol, and drug abuse as stated on the Application for Group Coverage, and the Group has made the elections noted thereon.**

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SUMMARY OF BENEFITS

PRESCRIPTION DRUG BENEFITS

Copayment Per Outpatient Prescription Or Refill -

	Retail	Mail
Tier 1	$7.00	$21.00
Tier 2	$30.00	$90.00
Tier 3	$55.00	$165.00
Tier 4	$70.00	$210.00
*Tier 5	$50.00	$150.00

Dispensing Limitation Per Prescription Or Refill
- Retail.....up to a 30 day supply
- Mail.....up to a 90 day supply
Specialty Drugs may be limited to a 30 day supply.

- "Limitations and Exclusions", 13., H. is deleted. Benefits are available for contraceptive drugs.

* Includes only covered injectable drugs purchased from a pharmacy. Injectable insulin and injectable antihemophilic Prescription Drugs are included in another tier.

Prescription Drug Step Therapy
[As currently provided in the Benefit Plan's Prescription Drug Utilization Program, in some cases the Group may require the Member to first try one Prescription Drug to treat a medical condition before the Group will cover another Prescription Drug for that condition. For example, if Drug A and Drug B both treat the Member's medical condition, the Group may require the Member's Physician to prescribe Drug A first. If Drug A does not work for the Member, then the Group will cover a Prescription written for Drug B. However, if Your physician's request for a Step B drug does not meet the necessary criteria to start a Step B drug without first trying a Step A drug, or if You choose a Step B brand-name drug included in the Step Therapy program without first trying a Step A generic alternative, You will be responsible for the full cost of the drug.]

[Categories of Prescription Drugs that require step therapy. As these categories may change from time to time, the Member may wish to call the customer service number on their I.D. card or check our website at www.bcbsla.com to determine what categories of Prescription Drugs are subject to step therapy: Examples may include but are not limited to:

- Blood Pressure Medications: (example: Angiotensin Converting Enzyme Inhibitors, Angiotensin II Receptor Blockers, Direct Renin Inhibitors)
- Pain Medications: (example: Non-Steroidal Anti-Inflammatory Drugs, COX-2 Inhibitors)
- Cholesterol Medications: (example: HMG-CoA Reductase Inhibitors)
- Sleep Medications: (example: Sedatives, Hypnotics)
- Stomach Acid Medications: (example: Proton Pump Inhibitors)
- Respiratory/Allergy Medications: (example: Nasal Antihistamines, Non-Sedating Antihistamines, Nasal Steroids)
- Depression Medications: (example: Selective Serotonin Reuptake Inhibitors, Serotonin/Norepinephrine Reuptake Inhibitors]

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The following categories of Prescription Drugs require prior authorization. The Member's Physician must call 1-800-376-7741 to obtain the authorization. Call the customer service number on the Member's I.D. card or check our website at www.bcbsla.com to determine what categories of Prescription Drugs require prior authorization.

[Categories of Prescription Drugs that require prior Authorization.

Specialty Drugs - Examples may include, but are not limited to
· Growth hormones*
· Anti tumor necrosis factor drugs*
· Intravenous immune globulin*
· Inteferons*
· Monoclonal antibodies*
· Hyaluronic acid derivatives for joint injection*

*Shall include all drugs that are in this category.

Controlled Dangerous Substances - Examples may include but are not limited to:
· Actiq®, OxyContin®]

SCHEDULE OF BENEFITS

Pharmacy Benefits

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