COMPREHENSIVE MAJOR MEDICAL PLAN

SCHEDULE OF BENEFITS

PLAN NAME		GROUP NUMBER
Louisiana Sheriffs' Association - Employees		722XX
PLAN'S ORIGINAL BENEFIT PLAN DATE	**PLAN'S AMENDED BENEFIT PLAN DATE**	**PLAN'S ANNIVERSARY DATE**
June 1, 1983	July 1, 2017	July 1st

BENEFIT PERIOD:	Calendar Year - January 1 through December 31

DEDUCTIBLE:

	ALL PROVIDERS
Benefit Period Deductible Amount - Individual:	$500.00
Family Deductible Amount* (Aggregate):	$1,500.00

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

SPECIAL NOTES:

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

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

Preventive or Wellness Care (Preferred Providers)

Services rendered as a result of an on the job injury or illness for Employee only

OUT-OF-POCKET AMOUNT – Includes the Benefit Period Deductible Amount.

Preferred Providers –	
Individual:	$6,000.00
Family:	$12,000.00
All Other Providers (Non-Network) –	
Individual:	$8,000.00
Family:	$12,000.00

SPECIAL NOTES:
Benefits for services of a Network Providers that accrue to the Out-of-Pocket Amount for Network Providers WILL ALSO 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 ALSO accrue to the Out-of-Pocket Amount for Network Providers.

MEDICAL BENEFITS – COPAYMENTS AND COINSURANCE:		
	PREFERRED CARE NETWORK	**NON-NETWORK** **All Other Providers**
Coinsurance shown as Company - Plan Participant responsibility		
Copayments shown are the Plan Participant's responsibility		
Inpatient and Outpatient Facility and Professional Services for Which a Copayment is not Applicable:	80% - 20%	60% - 40%
Inpatient Hospital Admission: Includes all Inpatient Hospital Facility Services.	$250.00 per Admission	$250.00 per Admission
Inpatient Professional / Physician Charges:	80% - 20%	60% - 40%
Accidental Injuries:	100% of Allowable Charges per Plan Participant, occurring while performing the duties of his job. Deductible waived	
Ambulance Services:	80% - 20%	60% - 40%
Ambulatory Surgical Center and Outpatient Surgical Facility:	80% - 20%	60% - 40%
Surgical Professional and Physician Charges:	80% - 20%	60% - 40%
Dietitian Visits:	80% - 20%	60% - 40%
Emergency Medical Services – performed in the Emergency Department of a Hospital: Includes Facility and Professional / Physician charges.	80% - 20%	80% - 20%
Home Health Care:	80% - 20%	60% - 40%

Hospice Care:	80% - 20%	60% - 40%
Hospice Care services limited to: one hundred eighty (180) days for hospice care, and it must be approved by the Plan's Claims Administrator prior to Admission to the facilit		
Mental Health and Substance Abuse Disorders:	80% - 20% Payable same as medical Benefits	60% - 40% Payable same as medical Benefits
Organ, Tissue, and Bone Marrow Transplants:	80% - 20%	80% - 20%
Authorization required prior to services being performed.		
Pregnancy Care:	80% - 20%	60% - 40%
Preventive or Wellness Care: See the "Preventive or Wellness Care" Article for more details on Preventive or Wellness Care Benefits.	100% - 0% Deductible Waived	60% - 40% Deductible Waived
Private Duty Nursing –	80% - 20%	60% - 40%
Outpatient Services Only:		
X-rays, Lab Tests, Machine Tests, and High Tech Imaging:		
X-Rays, Lab Tests and Machine Tests –	80% - 20%	60% - 40%
High Tech Imaging – such as CT, MRI, MRA, PET or Nuclear Cardiology.	80% - 20%	60% - 40%
Rehabilitative Care Services:	80% - 20%	60% - 40%
• Physical and Occupational Therapy		
• Speech Therapy		
• Chiropractic Services		
Skilled Nursing Facility:	80% - 20%	60% - 40%
Skilled Nursing Facility Benefits limited to: Sixty (60) days maximum, renewable if confinement period is separated by six months. Admission must follow minimum Hospital stay of three (3) days and must be within fourteen (14) days of discharge from Hospital.		

PRESCRIPTION DRUG COVERAGE:		
Prescription Drug Deductible Amount – per Plan Participant:		$150.00
Prescription Drug Deductible must be met prior to application of a Copayment.		
Prescription Drug Deductible applies to Brand Drugs only.		
Note: First Fill Free		

Prescription Drug Copayments – Member responsibility, per Outpatient prescription or refill.	**RETAIL**	**MAIL**
Tier 1 (Generic)	$10.00	$30.00
Tier 2 (Preferred Brand)	$30.00	$90.00
Tier 3 (Non-Preferred Brand)	$50.00	$150.00
Tier 4 (Specialty Drugs)	10% up to $100 Max	10% up to $100 Max
NOTE: Plan Participants will be charged an Ancillary fee if they choose a Brand Drug (Generic Copayment plus the difference of cost between Brand and Generic).		
Dispensing Limitation per Prescription or Refill:		
Retail:	Up to a thirty (30) day supply	
Retail - Maintenance Drugs:	Up to a (90) day supply, subject to copayment per thirty (30) day supply	
Mail Order:	Up to a ninety (90) day supply	
Specialty Drugs:	Limited to a thirty (30) day supply	
Therapeutic/Treatment Vaccines are subject to payment of Deductible and Coinsurance.		
Categories of Prescription Drugs that Require Prior Authorization:		
The following categories of Prescription Drugs require prior Authorization. The Plan Participant's Physician must call 1-800-376-7741 or 1-800-842-2015 to obtain the Authorization. The Plan Participant can call the customer service number on the back of his ID card or check at **www.bcbsla.com/pharmacy** to determine what categories of Prescription Drugs require prior authorization.		
Specialty Drugs – Examples may include, but are not limited to:		
• Growth hormones		
• Anti-tumor necrosis factor drugs*		
• Intravenous immune globulin		
• Interferons		
• Monoclonal antibodies*		
• Hyaluronic acid derivatives for joint injection*		
• Proprotein convertase subtilisin/kexin type 9 (PCSK-9) inhibitors (e.g. Praluent®, Repatha™)*		
* Shall include all drugs that are in this category.		
Traditional drugs that are not considered to be Specialty Drugs, are typically self administered, and commonly dispensed by retail pharmacies. Examples may include but are not limited to:		
• Provigil®, Nuvigil®, Symlin®, Byetta®, Victoza®		
Controlled Dangerous Substances – Examples may include, but are not limited to:		
• Actiq®, OxyContin®		

Therapeutic/Treatment Vaccines – Examples include, but are not limited to vaccines to treat the following conditions:

- Allergic Rhinitis
- Alzheimer's Disease
- Cancers
- Multiple Sclerosis
- Substance Addiction, if covered on this Plan

CARE MANAGEMENT

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. Requests for Authorization of Inpatient 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. This penalty applies to all covered Inpatient charges. 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 and Coinsurance percentage.

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. This penalty applies to all covered Inpatient charges. The Plan Participant is responsible for all charges not covered and for any applicable Copayment, Deductible and Coinsurance percentage.

Additional Plan Participant responsibility if Authorization is not requested for an Inpatient Admission to a Non-Participating Provider Hospital: **$1,000.00 reduction of the Allowable Charges**.

Authorization of Outpatient Services, Including Other Covered Services and Supplies:

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

Additional Network Provider responsibility if Authorization is not requested for Outpatient services and supplies: **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 Copayment, Deductible and Coinsurance percentage.

Additional Plan Participant responsibility if Authorization is not requested for Outpatient services and supplies furnished by a Non-Network Provider: **30% reduction of the Allowable Charges**.

The following services and supplies require Authorization prior to the services being rendered or supplies being received. Requests for Authorization must be made to Blue Cross and Blue Shield of Louisiana by calling 1-800-376-7973.

- Applied Behavior Analysis
- Bone Growth Stimulator
- Day Rehabilitation Programs
- Electric and Custom Wheelchairs
- High Tech Imaging (PET scan)
- Home Health Care
- Hospice Care
- Hyperbarics
- Implantable Medical Devices over $2,000.00 (such as Implantable Defibrillator and Insulin Pump)
- Intensive Outpatient Programs
- Non-Emergency Ambulance
- Organ Transplant and Evaluation
- Partial Hospitalization Programs
- Private Duty Nursing
- Prosthetic Appliances
- Residential Treatment Centers
- Sleep Studies, except for those done in the home
- Stereotactic Radiosurgery (including but not limited oto gamma knife and cyberknife provedures)
- Vacuum Assited Wound Closure Therapy
- Certain musculoskeletal procedures, including, but not limited to, spinal Surgeries and spinal injections
- Other Covered Services that are or may become subject to a Prior Authorization as then defined and administered by Us

ELIGIBILITY WAITING PERIOD

The Plan Administrator will determine the Eligibility Waiting Period and Effective Date of coverage for all eligible employees and their Dependents.