COMPREHENSIVE MAJOR MEDICAL PLAN		
SCHEDULE OF BENEFITS		
PLAN NAME		**GROUP NUMBER**
Louisiana Sheriffs' Association Group Benefits Program – Retiree Plan 2		722XXFF4
NETWORK		**PLAN TYPE**
Preferred Care PPO		PPO
PLAN'S ORIGINAL BENEFIT PLAN DATE	**PLAN'S AMENDED BENEFIT PLAN DATE**	**PLAN'S ANNIVERSARY DATE**
June 1, 1983	July 1, 2022	July 1st

BENEFIT PERIOD	Calendar Year – January 1 through December 31

BENEFIT PERIOD DEDUCTIBLE AMOUNTS	
Deductible Amounts listed apply to the 2022 Benefit Period.	**ALL PROVIDERS**
Individual Deductible Amount:	$1,000
Family Deductible Amount:	$3,000

Special Notes:

- A Plan Participant does not have to meet the Individual Deductible Amount to be eligible for the Family Deductible Amount.
- No family Member may contribute more than his Individual Benefit Period Deductible Amount to satisfy the aggregate Deductible Amount required of a family.
- 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 Accural:

- The Deductible Amount is a single amount that includes eligible charges incurred from all Providers combined.
- Benefits for Emergency Services of Non-Network Providers WILL accrue to the Deductible Amount for Network Providers.
- Benefits for Non-Emergency Services performed by 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 or Wellness Care (All Providers)
- Services rendered as a result of an on-the-job injury or illness for Employee only
- Telehealth (Network Providers)

MAXIMUM OUT-OF-POCKET AMOUNTS – *Each Benefit Period.*		
Includes the Benefit Period Deductible Amount.	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
Individual Out-of-Pocket Amount:	$6,850	$9,130
Family Out-of-Pocket Amount:	$13,700	$13,700
Special Notes:		
• After the Plan Participant has met the applicable Out-of-Pocket Amount, as shown on this Schedule of Benefits, the Plan will pay one hundred percent (100%) of the Allowable Charges for Covered Services for all family Members for the remainder of the Benefit Period. • 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 Accural:		
• 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. • Benefits for Emergency 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 Providers at Network facilities WILL accrue to the Out-of-Pocket Amount for Network Providers.		

MEDICAL BENEFITS – COPAYMENTS AND COINSURANCE		
The Benefit Period Deductible Amount <u>applies</u> unless otherwise stated.	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
Coinsurance shown as Company – Plan Participant responsibility.		
Copayments shown are the Plan Participant's responsibility.		
Accupuncture: • Limited to twelve (12) visits per Benefit Period.	70% - 30%	50% - 50%
Ambulance Services:		
<u>Air Ambulance</u> **Applies Network Deductible.*	70% - 30%	70% - 30%*
<u>Ground Ambulance</u>	70% - 30%	50% - 50%
Ambulatory Surgical Center and Outpatient Surgical Facility:	70% - 30%	50% - 50%
Surgical Professional and Physician Charges	70% - 30%	50% - 50%

Dietitian Visits: ** First visit covered at one hundred percent (100%), Deductible waived.*	70% - 30%*	50% - 50%
Emergency Medical Services: Performed in the Emergency Department of a Hospital. Includes Facility and Professional / Physician charges. **Applies Network Deductible.*	70% - 30%	70% - 30%*
High-Tech Imaging: Imaging Services which include, but are not limited to, MRIs, MRAs, CT Scans, PET Scans, or Nuclear Cardiology.	70% - 30%	50% - 50%
Home Health Care:	70% - 30%	50% - 50%
Hospice Care: • Limited to one hundred eighty (180) days.	70% - 30%	50% - 50%
Inpatient Hospital Admission: Includes Professional / Physician charges.	$250 Facility Copayment, then 70% - 30%	$250 Facility Copayment, then 50% - 50%
Low-Tech Imaging and Laboratory Tests: Imaging Services which include, but are not limited to, x-rays, machine tests and diagnostic imagining.	70% - 30%	50% - 50%
Mental Health and Substance Use Disorder: ** First follow-up visit covered at one hundred percent (100%).*	70% - 30%	50% - 50%
Organ, Tissue, and Bone Marrow Transplants:	70% - 30%	50% - 50%
Pregnancy Care: *Covered Dependent Children are not eligible for Pregnancy care benefits.*	70% - 30%	50% - 50%

Preventive or Wellness Care: See the "Preventive or Wellness Care" Article for more details on Preventive or Wellness Care Benefits. ** Deductible waived.*	100% - 0%*	50% - 50%*
Private Duty Nursing (Outpatient Services Only):	70% - 30%	50% - 50%
Rehabilitative Care Services: Physical Therapy Occupational Therapy Speech Therapy Chiropractic Services Cardiac Rehabilitation Therapy Pulmonary Rehabilitation Therapy	70% - 30%	50% - 50%
Skilled Nursing Facility: • 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.	70% - 30%	50% - 50%
Telehealth:	$20 per visit	50% - 50%
Urgent Care:	70% - 30%	50% - 50%

PRESCRIPTION DRUG COVERAGE – CLOSED FORMULARY
Pharmacy Benefits are administered by Blue Cross and Blue Shield of Louisiana. This Plan utilizes a Closed Prescription Drug Formulary. For more information, please refer to the Pharmacy section of Your Benefit Plan.

PRESCRIPTION DRUG DEDUCTIBLE	
Prescription Drug Deductible must be met prior to application of a Copayment.	**AMOUNT**
Individual: *per Plan Participant* **Prescription Drug Deductible applies to Brand-Name Drugs only. First Fill Free.*	$150*

PRESCRIPTION DRUG COPAYMENTS		
Plan Participant's responsibility, per Outpatient prescription or refill.	**RETAIL**	**MAIL**
Tier 1 – Value Drugs	$15	$45
Tier 2 – Brand-Name Drugs	$40	$120
Tier 3 – Primarily Brand-Name Drugs	$70	$210
Tier 4 – Specialty Drugs *Plan Participant pays ten percent (10%) of the Allowable Charge up to one hundred dollars ($100) maximum.*	10%	10%
Dispensing Limitation per Prescription or Refill:		
Retail:	Up to a thirty (30) day supply	
Retail – Maintenance Drugs:	Up to an eighty-four to ninety (84 - 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	
Special Notes:		

- 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).
- Select diabetic supplies, including but not limited to, necessary Continuous Glucose Monitors (CGM) and associated Supplies, insulin syringes, and test strips are covered under the Prescription Drug Benefit.
- Contraceptives are included.
- Therapeutic/Treatment Vaccines are subject to payment of Deductible and Coinsurance.

PRESCRIPTION DRUG STEP THERAPY
As currently provided in the Benefit Plan's Prescription Drug Utilization Program, in some cases the Claims Administrator may require the Plan Participant to first try one or more Prescription Drugs to treat a medical condition before the Claims Administrator will cover another Prescription Drug for that condition. For example, if Drug A and Drug B both treat the Plan Participant's medical condition, the Claims Administrator may require the Plan Participant's Physician to prescribe Drug A first. If Drug A does not work for the Plan Participant, then the Claims Administrator will cover a prescription written for Drug B. However, if Your Physician 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 Drug included in the Step Therapy program without first trying a Step A alternative, You will be responsible for the full cost of the Drug.
The following are categories of Prescription Drugs that require Step Therapy. As these categories may change from time to time, the Plan Participant may wish to call the customer service number on their ID card or check the website at **www.bcbsla.com/pharmacy** to determine what categories of Prescription Drugs are subject to Step Therapy. Examples may include but are not limited to the following:
• 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)

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUIREMENTS
The following categories of Prescription Drugs require Prior Authorization. The Plan Participant's Physician must call **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 the website at **www.bcbsla.com/pharmacy** to determine what categories of Prescription Drugs require Prior Authorization.
Compound Drugs – over $250
Controlled Dangerous Substances – Examples may include, but are not limited to:
• Actiq®, OxyContin®
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.

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 Use Disorder
Traditional Drugs – These 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®

CARE MANAGEMENT– PRIOR AUTHORIZATIONS

Requests for Authorization must be made to Blue Cross and Blue Shield of Louisiana by calling **1-800-523-6435.**

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 and Emergency 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, Emergency Admissions and 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**.

Network Providers

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, Deductible Amount and Coinsurance.

NOTE: Benefits for Participating Providers will be paid at the lower Non-Network level shown on this Schedule of Benefits.

Non-Network Providers

If a Non-Network Provider or Non-Participating Provider fails to obtain a required Authorization, the Claims Administrator will reduce Allowable Charges by the amount shown in the Schedule of Benefits. This penalty applies to all covered Inpatient charges. The Plan Participant is responsible for all charges not covered and for any applicable Copayment, Deductible Amount and Coinsurance.

Additional Plan Participant responsibility if Authorization is not requested for an Inpatient Admission to a Non-Participating Provider Hospital: **One Thousand dollars ($1,000) reduction of the Allowable Charges**.

AUTHORIZATION OF OUTPATIENT SERVICES AND SUPPLIES

Network Providers

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 any applicable Copayment, Deductible Amount and Coinsurance.

Additional Network Provider responsibility if Authorization is not requested for Outpatient services and supplies: **Thirty percent (30%) reduction of the Allowable Charges**.

Non-Network Providers

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 Amount and Coinsurance.

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

SERVICES THAT REQUIRE PRIOR AUTHORIZATION

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

- Air Ambulance Non-Emergency *(No Benefit without Prior Authorization.)*
- Applied Behavior Analysis
- Arterial Ultrasound
- Arthroscopy and Open procedures *(Shoulder and Knee)*
- Bone Growth Stimulator
- Cardiac Rehabilitation
- Cellular Immunotherapy
- Coronary Arteriography
- CT Scans
- Day Rehabilitation Programs
- Electric and Custom Wheelchairs
- Gene Therapy
- Genetic or Molecular Testing
- Hip Arthroscopy
- Home Health Care
- Hospice
- Hyperbarics
- Implantable Medical Devices over $2,000, including but not limited to defibrillators
- Insulin Pumps
- Intensive Outpatient Programs
- Interventional Spine Pain Management

- Joint Replacement *(Hip, Knees and Shoulders)*
- Low Protein Foods
- Meniscal Allograft Transplantation of the Knee
- MRI/MRA
- Nuclear Cardiology
- Partial Hospitalization Programs
- Percutaneous Coronary Interventions such as Coronary Stents and Balloon Angioplasty
- PET Scans
- Private Duty Nursing
- Prosthetic Appliances
- Pulmonary Rehabilitation
- Residential Treatment Centers
- Resting Transthoracic Echocardiography
- Sleep Studies, except those performed as a home sleep study
- Spine Surgery
- Stress Echocardiography
- Transesophagael Echocardiography
- Transplant Evaluation & Transplants
- Treatment of Osteochondral Defects
- Vacuum Assited 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.