COMPREHENSIVE MAJOR MEDICAL PLAN		
SCHEDULE OF BENEFITS		
PLAN NAME		**GROUP NUMBER**
Louisiana Sheriffs' Association Group Benefits Program – Retiree Plan 1		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, 2024	July 1

BENEFIT PERIOD	Calendar Year – January 1 through December 31

BENEFIT PERIOD DEDUCTIBLE AMOUNTS – *Each Benefit Period.*	
Deductible Amounts listed apply to the 2024 Benefit Period.	**ALL PROVIDERS**
Individual:	$1,000
Family:	$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 Accrual:

- The Deductible Amount is a single amount that includes eligible charges incurred from all Providers combined.
- Benefits for Emergency Services of Network and 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 *(Employee only)*
- Telehealth Services and Remote Patient Therapy Services *(Network Providers)*

OUT-OF-POCKET AMOUNTS – *Each Benefit Period.*		
Includes the Benefit Period Deductible Amount.	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
Individual:	$6,000	$8,000
Family:	$12,000	$12,000

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 Accrual:

- 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 Network and 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.

STANDARD COINSURANCE PERCENTAGE AMOUNTS		
Coinsurance shown as Company – Plan Participant responsibility.	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
	80% - 20%	60% - 40%

Special Notes:

- Coinsurance shown is paid until the Out-of-Pocket Amount has been met. The Plan pays one hundred percent (100%) thereafter for the remainder of the Benefit Period up to the maximum.
- Services for which a special Deductible Amount is applicable will be noted accordingly. A special Deductible Amount is an amount different than the stated Standard Deductible Amount appliable to the Network Tier (i.e., Network or Non-Network).

MEDICAL BENEFITS – COPAYMENTS AND COINSURANCE		
The Benefit Period Deductible Amount applies unless otherwise stated.	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
	Coinsurance shown as Company – Plan Participant responsibility.	
	Copayments shown are the Plan Participant's responsibility.	
Ambulance Services:		
Air Ambulance ** Applies Network Deductible.*	80% - 20%	80% - 20%*
Emergency Ground Ambulance Services In-State ** Applies Network Deductible.*	80% - 20%	80% - 20%*
Emergency Ground Ambulance Services Out-of-State	80% - 20%	60% - 40%
Non-Emergency Ground Ambulance Services	80% - 20%	60% - 40%
Ambulatory Surgical Center and Outpatient Surgical Facility: Includes Surgical Professional and Physician Charges**.**	80% - 20%	60% - 40%
Dietitian Visits: ** First visit covered at one hundred percent (100%).*	80% - 20%*	60% - 40%
Emergency Medical Services: Includes Professional and Physician Charges. ** Applies Network Deductible.*	80% - 20%	80% - 20%*
High-Tech Imaging: Imaging Services which include, but are not limited to, MRIs, MRAs, CT Scans, PET Scans, or Nuclear Cardiology.	80% - 20%	60% - 40%
Home Healthcare:	80% - 20%	60% - 40%
Hospice Care:	80% - 20%	60% - 40%
Inpatient Hospital Admission:		
Facility Charges	$250	$250
Professional/Physician Charges	80% - 20%	60% - 40%

Low-Tech Imaging and Laboratory Tests: Imaging Services which include, but are not limited to, x-rays, machine tests and diagnostic imagining.	80% - 20%	60% - 40%
Mental Health and Substance Use Disorder: ** First follow-up visit covered at one hundred percent (100%).*	80% - 20%*	60% - 40%
Organ, Tissue, and Bone Marrow Transplants:	80% - 20%	60% - 40%
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. ** Deductible waived.*	100% - 0%*	60% - 40%*
Private Duty Nursing (Outpatient Services Only):	80% - 20%	60% - 40%
Rehabilitative Care Services:	80% - 20%	60% - 40%
Physical Therapy Occupational Therapy Speech Therapy Chiropractic Services Cardiac Rehabilitation Therapy Pulmonary Rehabilitation Therapy		
Skilled Nursing Facility: • Limited to sixty (60) days maximum. • Renewable if confinement period is separated by six (6) months. • Admission must follow minimum Hospital stay of three (3) days and must be within fourteen (14) days of discharge from Hospital.	80% - 20%	60% - 40%
Telehealth Services and Remote Patient Therapy Services:	$20	60% - 40%
Urgent Care:	80% - 20%	60% - 40%

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 shown applies to Brand-Name Drugs only and must be met prior to application of a Copayment. First Fill Free.	**AMOUNT**
Individual: *per Plan Participant*	$150

PRESCRIPTION DRUG COPAYMENTS		
Plan Participant's responsibility, per Outpatient prescription or refill.	**RETAIL**	**MAIL ORDER**
Tier 1 – Value Drugs	$10	$30
Tier 2 – Brand-Name Drugs	$30	$90
Tier 3 – Primarily Brand-Name Drugs	$50	$150
Tier 4 – Specialty Drugs *(may fall within either tier.)*	10% *up to $100 max*	N/A

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:

Included Drugs

- Contraceptives are included.
- Specialty Drugs may be subject to prior Authorization requirements.
- Therapeutic/Treatment Vaccines are subject to payment of Deductible and Coinsurance.
- Continuous Glucose Monitors (CGM) and associated supplies are included.

Specialty Drugs

- Specialty Drugs may fall may be subject to Prior Authorization requirements.

$0 Drug Copay Program (ZDC)

Certain drugs in selected Prescription Drug categories commonly used to treat selected chronic conditions (e.g., Asthma, COPD – Chronic Obstructive Pulmonary Disease, CHD – Coronary Heart Disease, Diabetes, Heart Failure, etc.) are available at one hundred percent (100%), Deductible / Copayment waived (no cost share to the Plan Participant) when a certain drug is purchased at a Network Pharmacy.

Ancillary Fee For Multi-Source Brand-Name Drugs

When a Brand-Name Drug is dispensed and a Generic equivalent exists, the Plan Participant must pay the Tier 1 Copayment Amount, plus the difference in cost between the Brand-Name Drug dispensed and its Generic equivalent. The Copayment for the Brand-Name Drug will not apply. The Plan Participant's payment will apply to the Out-of-Pocket Amount.

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.

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 **1-800-523-6435** to obtain the Authorization. The Plan Participant can call the customer service number or visit Our 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.

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
Your Schedule of Benefits lists the specific services, supplies and Prescription Drugs that require Authorization. For more information on those items and services visit Our website, **www.bcbsla.com/priorauth**. 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 services is NOT a guarantee of payment. Penalty amounts do not accrue to the Deductible amount or 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**.	
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. 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 and Non-Participating Providers will be paid at the lower Non-Network level shown on this Schedule of Benefits.
NON-NETWORK PROVIDERS	If a Non-Participating Provider fails to obtain a required Authorization, We will reduce Allowable Charges by the penalty shown below. The Plan Participant is responsible for all charges not covered and for any applicable penalty, Copayment, Deductible Amount and Coinsurance. **PENALTY AMOUNT:** $1,000 reduction of the Allowable Charges.

AUTHORIZATION FOR OUTPATIENT SERVICES, INCLUDING OTHER COVERED SERVICES AND SUPPLIES	
If a Provider fails to obtain Authorization for the Outpatient services and supplies which indicate No Benefit without written / prior Authorization on the prior Authorization list below, the Outpatient services and supplies are not covered.	
NETWORK PROVIDERS	If a Network Provider fails to obtain a required Authorization, We will reduce the Allowable Charges by the penalty stipulated in the Provider's contract. This penalty applies to all Outpatient 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.
NON-NETWORK PROVIDERS	If a Non-Network Provider fails to obtain a required Authorization, We will reduce Allowable Charges by the penalty shown below. This penalty applies to all Outpatient 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. **PENALTY AMOUNT:** 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. The list of services requiring Authorization may change from time-to-time. Providers may request a pre-determination of Medical Necessity prior to rendering services. Requests for Authorization or a pre-determination of Medical Necessity must be to Blue Cross and Blue Shield of Louisiana by calling **1-800-523-6435**.
• 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 *(No Benefit without Prior Authorization.)*
• Coronary Arteriography
• CT Scans
• Day Rehabilitation Programs
• Electric and Custom Wheelchairs
• Gene Therapy *(No Benefit without Prior Authorization.)*
• Genetic or Molecular Testing
• Hip Arthroscopy
• Home Healthcare
• Hospice
• Hyperbarics
• Implantable Medical Devices over $2,000, including but not limited to defibrillators
• Intensive Outpatient Programs
• Interventional Spine Pain Management
• Joint Replacement *(Hip, Knees and Shoulders)*
• Low Protein Food Products
• 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
• Transesophageal Echocardiography
• Transplant Evaluation & Transplants *(No Benefit without Prior Authorization.)*
• Treatment of Osteochondral Defects
• 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.

Retiree Coverage Effective Date: First of the month following retirement.

Note: *No Dependent Coverage Included.*