COMPREHENSIVE MEDICAL BENEFIT PLAN

SCHEDULE OF BENEFITS

PLAN NAME		GROUP NUMBER
Vermilion Parish School Board Option 2		78K22ERC
PLAN'S ORIGINAL BENEFIT PLAN DATE	**PLAN'S AMENDED BENEFIT PLAN DATE**	**PLAN'S ANNIVERSARY DATE**
June 1, 2016	January 1, 2018	January 1st

BENEFIT PERIOD:	Calendar Year - January 1 through December 31

DEDUCTIBLE:

	NETWORK PROVIDERS	NON-NETWORK ALL OTHER PROVIDERS
Individual Benefit Period Deductible Amount:	$2,000	$4,000
Family Deductible Amount*:	$6,000	$12,000

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

SPECIAL NOTES:

Benefits for services of Network Providers that accrue to the Deductible Amount for Network Providers WILL NOT accrue to the Deductible Amount for Non-Network Providers.

Benefits for services of Non-Network Providers that accrue to the Deductible Amount for Non-Network Providers WILL NOT accrue to the Deductible Amount for Network Providers.

Benefits for Emergency Services of Non-Network Providers that accrue to the Deductible Amount for Non-Network Providers WILL ALSO accrue to the Deductible Amount for Network Providers.

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

Preventive or Wellness Care (All Providers)

X-Rays, Lab Tests and Machine Tests (Network Providers)

OUT-OF-POCKET AMOUNT – Includes the Benefit Period Deductible Amount.
NETWORK Providers
Individual: $6,250
Family: $12,500
All Other Providers (Non-Network)
Individual: $12,500
Family: $25,000
SPECIAL NOTES:
Benefits for services of NETWORK Providers that accrue to the Out-of-Pocket Amount for NETWORK Providers WILL NOT 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 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:		
	NETWORK PROVIDERS	**NON-NETWORK ALL OTHER PROVIDERS**
Deductible applies unless otherwise stated.		
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:	70% - 30%	50% - 50%
Primary Care Office Visits for the following Providers:	$40 per visit	50% - 50%
Family Practice		
General Practice		
Internal Medicine		
Pediatrics		
Geriatrics		
Obstetrician / Gynecologist		
Nurse Practitioner		
Physician Assistant		
Retail Health Clinic		
Advanced Practice Registered Nurse		
Certified Mid-Wife		
Chiropractor		
Independent Lab		
Registered Nurse First Assistant		

MEDICAL BENEFITS – COPAYMENTS AND COINSURANCE CONT'D		
Quality Blue Care Providers: Reduced Office Visit Copayment applies to Network Providers with the QBPC designation.	$25 per visit	50% - 50%
Specialists Office Visits for the following Allied Health Professionals:	$55 per visit	50% - 50%
Audiologist		
Licensed Clinical Social Worker		
Licensed Professional Counselor		
Ophthalmologist		
Optometrist		
Podiatrist		
Psychiatrist		
Psychologist		
Registered Dietitian		
The following Services listed below will be covered at 100% if the Plan Participant does not receive an office visit bill: • Injections, allergy testing and serums, vials of allergy medications.		
Inpatient Hospital Admission: Includes all Inpatient Hospital Facility Services and Professional/ Physician Charges.	70% - 30%	50% - 50%
Accidental Injuries: o Limited to Dental Services - Accident Only	70% After the Deductible	70% After the Deductible
Emergency Medical Services: Performed in the Emergency Department of a Hospital: Includes Facility and Professional / Physician charges. *Copayment is waived if the Plan Participant is admitted.	$350* per visit then 100%	$350* per visit then 100%
Emergency Ambulance Services:	70% - 30%	70% - 30%
Ambulatory Surgical Center and Outpatient Surgical Facility: Includes Facility and Professional / Physician Services.	70% - 30%	50% - 50%
Dietitian Visits:	$55 per visit	50% - 50%
Hearing Aid Benefits:		
Ages 17 and under • Limited to a (1) one purchase (including repair/replacement) per hearing impaired ear every (3) three years. Ages 18 and up • Limited to $2,500 per Plan Participant each Benefit Period. • Limited to a (1) one purchase (including repair/replacement) per hearing impaired ear every (3) three years.	70% - 30%	50% - 50%
Home Health Care: Limited to 60 visits per Plan Participant each Benefit Period.	70% - 30%	50% - 50%
Hospice Care:	70% - 30%	50% - 50%

MEDICAL BENEFITS – COPAYMENTS AND COINSURANCE CONT'D		
Mental Health and Substance Use Disorders:		
Office visit for Mental Health and Substance Use Disorder Benefits	$55 per visit	50% - 50%
All other Mental Health and Substance Use Disorder Services	70% - 30%	50% - 50%
Organ, Tissue, and Bone Marrow Transplants: Authorization required prior to services being performed.	70% - 30%	50% - 50%
Pregnancy Care: See the "Pregnancy Care and Newborn Care" Article for more details on Pregnancy Care and Newborn 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.	100% Deductible Waived	50% - 50% Deductible Waived
X-rays, Lab Tests, Machine Tests, and High-Tech Imaging:		
X-Rays, Lab Tests and Machine Tests –	100%* *Copayment is waived if the Plan Participant does not receive an office visit bill.	50% - 50%
High-Tech Imaging – such as CT, MRI, MRA, PET, or Nuclear Cardiology.	70% - 30%	50% - 50%
Rehabilitative Care Services: • Physical Therapy • Occupational Therapy • Speech Therapy	70% - 30%	50% - 50%

• Chiropractic Services
  • Limited to 20 visits per Plan Participant each Benefit Period
  • Includes modalities and manipulations
• Cardiac Rehabilitation
  • Limited to 36 visits per Plan Participant each Benefit Period
• Post-Cochlear Implant Aural Therapy
• Pulmonary Rehabilitation
	$40 per visit	50% - 50%

Skilled Nursing Facility: Limited to 90 days per Plan Participant each Benefit Period.	70% - 30%	50% - 50%
Urgent Care Center:	$55 per visit	50% - 50%
Vision Care Exam: Limited to one exam in a 24 month period.	$55 per visit	Not Covered

PRESCRIPTION DRUG COVERAGE:		
Prescription Drug Copayments – Member responsibility, per Outpatient prescription or refill.	**RETAIL**	**MAIL**
Tier 1 – Value Drugs	$7	$21
Tier 2 – Preferred Brand Drugs	$30	$90
Tier 3 – Non-Preferred Brand/Generic Drugs	$70	$210
Tier 4 – Specialty Drugs*	10% up to $150 Maximum	10% up to $150 Maximum
*NOTE: Contracted Specialty Pharmacies must be utilized if the Managed Specialty Pharmacy Program is selected.		
Dispensing Limitation per Prescription or Refill:		
Retail:	Up to a thirty (30) day supply	
Retail - Maintenance Drugs:	Up to a ninety (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.		

Prescription Drug Step Therapy

Certain drugs and/or drug classes are subject to Step Therapy. In some cases, the Plan Participant may be required to first try one or more Prescription Drugs to treat a medical condition before the Plan 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 Plan Participant's Physician may be required to prescribe Drug A first. If Drug A does not work for the Plan Participant, then the Plan 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 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)

Categories of Prescription Drugs that Require Prior Authorization:

The following categories of Prescription Drugs require prior Authorization. The Plan Participant's Physician must call 1-800-842-2015 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.

Compound Drugs over $100.00

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 Use Disorder

CARE MANAGEMENT

Requests for Authorization must be made to Blue Cross and Blue Shield of Louisiana by calling **1-800-376-7973.**

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.

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-Network Provider fails to obtain a required Authorization, services and/or supplies will not be covered and the Plan Participant must pay all charges incurred.

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

If Authorization is not requested prior to a listed service or supply being rendered, the Plan Participant's claim may be reviewed for Medical Necessity. If it was Medically Necessary, Benefits will be provided based on the Network status of the Provider of the service or supply.

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 all charges and for any applicable Copayment, Deductible and Coinsurance percentage.

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

If a Non-Network Provider fails to obtain a required Authorization, services and/or supplies will not be covered and the Plan Participant must pay all charges incurred.

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

- Air Ambulance (Non-Emergency)
- Applied Behavior Analysis
- Bone growth stimulator
- Cardiac Rehabilitation
- Day Rehabilitation Programs
- Dialysis
- Durable Medical Equipment (Greater than $300.00)
- Electric & Custom Wheelchairs

• High-Tech Imaging (MRI / MRA, CT scan, PET scan and Nuclear Cardiology)
• Home Health Care
• Hospice Care
• Hyperbarics
• Implantable Medical Devices over $2000.00, such as Implantable Defibrillator and Insulin Pump
• Infusion Therapy not performed in a Physician's office, other than chemotherapy
• Intensive Outpatient Programs
• Orthotic Devices (greater than $300)
• Outpatient pain rehabilitation or pain control programs
• Partial Hospitalization Programs
• Prosthetic Appliances
• Residential Treatment Centers
• Sleep Studies(except those performed as a home sleep study)
• 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.
• Active Employees: The eligibility date is the first day of the month following thirty (30) days of employment.
• Under no circumstances will the initial Eligibility waiting period ever exceed ninety (90) days following the date of hire.