CALCASIEU PARISH SCHOOL BOARD		
SCHEDULE OF BENEFITS		
Plan Name:		Group Number:
Calcasieu Parish School Board High Option		**77376FF4**
Network:		Product Type:
Preferred Care PPO		**PPO**
Plan's Original Benefit Date:	Plan's Amended Benefit Date:	Plan's Anniversary Date:
May 1st, 2013	**May 1st, 2023**	**May 1st**
Benefit Period:	Calendar Year - January 1 through December 31	

MEDICAL DEDUCTIBLE:		
Deductible Amounts listed apply to the 2023 Benefit Period.	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
Individual Deductible Amounts:	$1,250	$2,500
Family Deductible Amounts:	$3,750	$7,500
Special Notes:		
• A Plan Participant does not have to meet the individual Benefit Period Deductible Amount to be eligible for the Family Deductible Amount • Benefits for Emergency Services from Non-Network Providers that accrue to the Deductible Amount for Non-Network Providers WILL ALSO accrue to the Deductible Amount for Network Providers. • 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:		
• 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 ALSO 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:		
• Preventive or Wellness Care (Network Providers)		

OUT-OF-POCKET AMOUNT:		
The Following accrue to the Out-of-Pocket Amounts: Copayments, Deductibles, and Coinsurance.	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
Individual Out-of-Pocket Amounts:	$4,000	$8,000
Family Out-of-Pocket Amounts:	$12,000	$24,000
Special Notes:		
• Benefits for Emergency Services of Network Providers that accrue to the Out-of-Pocket Amount for Network Providers WILL ALSO accrue to the Deductible Amount for Non-Network Providers. • 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 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 ALSO 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 – OFFICE VISIT COPAYMENTS:		
Copayments shown are the Plan Participants responsibility per visit. *Office Visit Copayments only apply to Network Providers.*	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
Office Visit Copayment for the following Providers:	$30 copayment	55% - 45%
Osteopath		
Opthalmologist – Excluding Surgical Procedures		
Optometrist		
Nurse Practitioner		
Physician		
Physician Assistant		
Podiatrist		
Retail Health Clinic		
Telehealth Visits		
Urgent Care Clinic		
Office Visit Copayment for Specialist Providers:	$45 copayment	55% - 45%

MEDICAL BENEFITS – COPAYMENTS & COINSURANCE: Unless a Copayment is noted, the following are subject to Deductible and Coinsurance.		
Coinsurance shown as Company – Plan Participant responsibility. *Copayments shown are the Plan Participant's responsibility.*	**NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
Ambulance Services:		
Air Ambulance Services:	85% - 15%	85% - 15%
Ground Ambulance Services:	85% - 15%	55% - 45%
Ambulatory Surgical Center and Outpatient Surgical Facility: Includes all Surgical Professional and Physician Charges	85% - 15%	55% - 45%
Dentofacial Anomalies: Benefit limited to one thousand dollars ($1,000) per Plan Participant per lifetime.	85% - 15%	55% - 45%
Durable Medical Equipment:	85% - 15%	55% - 45%

Emergency Medical Services:	85% - 15%	85% - 15%
High Tech Imaging: Benefit Includes CT, MRI, MRA, PET, or Nuclear Cardiology. PET scans require prior authorization.	85% - 15%	55% - 45%
Home Health Care:	85% - 15%	55% - 45%
Hospice Care: Bereavement Counseling services are available under Hospice Care for all covered family Members of a Plan Participant in Hospice Care prior to and within six (6) months following the Plan Participant's death. These services require prior authorization.	85% - 15%	55% - 45%
Inpatient Hospital Admission: Includes all Inpatient Hospital Facility Services.	85% - 15%	55% - 45%
Mental Health and Substance Use Disorders: Inpatient Services require prior authorization.	85% - 15%	55% - 45%
Office Visits:	$30 copayment	55% - 45%
Organ, Tissue and Bone Marrow Transplants: Expenses for transportation, lodging and meals for the Plan Participant and family Members are limited to a maximum amount of two hundred dollars ($200) per day up to a maximum amount of ten thousand dollars ($10,000) per year. These services require prior authorization.	85% - 15%	55% - 45%
Pregnancy Care: Includes Physician services only. Pregnancy Care services received from other Providers (such as Hospital, Emergency Room, Urgent Care or Ambulatory Surgical Centers) are subject to the applicable Deductible, Copayments or Coinsurance shown for each, if any.	$30 copayment for the first visit, then 85% - 15%	55% - 45%
Preventive or Wellness Care: See the "Preventive or Wellness Care" Article for more details on Preventive or Wellness Care Benefits.	100% - 0%	55% - 45%
Private Duty Nursing: Benefit limited to Outpatient Services only.	85% - 15%	55% - 45%
Rehabilitative Care Services: Inpatient Admission and Day Rehabilitation programs must begin within seventy two (72) hours following discharge from an Inpatient Hospital for the same or a similar condition. The Plan Participant must be able to tolerate a minimum of three (3) hours of active therapy per day. These services require authorization prior to admission.	85% - 15%	55% - 45%
Skilled Nursing Facility:	85% - 15%	55% - 45%

Urgent Care Center:	$30 copayment	55% - 45%
Low-Tech Imaging and Laboratory Tests: Imaging Services which include, but are not limited to, x-rays, machine tests and diagnostic imagining.	85% - 15%	55% - 45%

PRESCRIPTION DRUG DEDUCTIBLE:	
The Prescription Drug Deductible is Separate from the Medical Deductible.	**ALL PROVIDERS**
Individual Prescription Drug Deductible Amount:	$100
Special Notes:	
• Prescription Drug Deductible must be met prior to the application of a Copayment. • The Prescription Drug Deductible does not accrue to the Medical Deductible. • The Prescription Drug Deductible accrues to the Out-of-Pocket amount.	

PRESCRIPTION DRUG BENEFITS – COPAYMENTS & COINSURANCE:		
Copayments shown are the Plan Participant's responsibility per visit.	**RETAIL**	**MAIL ORDER**
Tier 1 –	$10	$30
Tier 2 –	$30	$90
Tier 3 –	$50	$150
Tier 4 –	$100	$125
Retail:	Limited to a thirty (30) day supply	
Retail - Maintenance:	Limited to a ninety (90) day supply	
Mail Order:	Limited to a ninety (90) day supply	
Specialty Drugs may fall within either tier:	Limited to a thirty (30) day supply	
Special Notes:		
• Deductible and Coinsurance applies to Therapeutic/Treatment Vaccines. • Zostavax is covered according to the American Medical Association age recommendations. • Covered Compound Drugs are covered as Tier 3 Drugs.		

PRESCRIPTION DRUG STEP THERAPY:

Certain drugs and/or drug classes are subject to Step Therapy. In some cases, the Plan may require the Plan Participant to first try one or more Prescription Drugs to treat a medical condition before it will cover another Prescription Drug for that condition. For example, if a Tier 1 and Tier 2 drug both treat the Plan Participant's medical condition, the Plan may require the Plan Participant's Physician to prescribe the Tier 1 drug first. If the Tier 1 drug does not work for the Plan Participant, then the Plan will cover a prescription written for the Tier 2 drug. However, if Your Physician's request for a Tier 2 drug does not meet the necessary criteria to start a Tier 2 drug without first trying a Tier 1 drug, or if You choose a Tier 2 drug included in the Step Therapy program without first trying a Tier 1 alternative, You will be responsible for the full cost of the drug. Additional information is available on the Schedule of Benefits for Rx Tier Information, or by visiting **www.bcbsla.com** or calling the customer service telephone number on the Plan Participant's ID Card.

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 visit Our website at **www.bcbsla.com/pharmacy** to determine what categories of Prescription Drugs require prior authorization.
Compound Drugs over $100
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*
* 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 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.

If a Non-Network 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 Deductible and Coinsurance percentage.

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

AUTHORIZATION OF OUTPATIENT SERVICES, INCLUDING OTHER COVERED SERVICES AND SUPPLIES:

If a Network Provider or a Participating Provider fails to obtain a required Authorization, We will reduce the 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 the applicable Deductible Amount and Coinsurance percentage.

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

If a Non-Network Provider fails to obtain a required Authorization, Benefits will be paid at the lower Non-Network level shown on this Schedule of Benefits. The Plan Participant is responsible for all charges not covered and for any applicable Deductible Amount and Coinsurance percentage**.**

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)
- Cardiac Rehabilitation
- Cellular Immunotherapy
- Day Rehabilitation Programs

• Gene Therapy
• Home Health Care
• Hospice
• Hyperbarics
• Intensive Outpatient Programs
• Low Protein Foods
• Partial Hospitalization Programs
• PET Scan
• Private Duty Nursing
• Prosthetic Appliances
• Pulmonary Rehabilitation
• Residential Treatment Centers
• Surgical Treatment of Erectile Dysfunction (including penile implants)
• Transplant Evaluation & Transplants

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 exceed ninety (90) days following the date of Hire.