CENTENARY COLLEGE OF LOUISIANA

SCHEDULE OF BENEFITS

PLAN NAME		GROUP NUMBER
CENTENARY COLLEGE OF LOUISIANA HDHP-HMO		78L11ERC
PLAN'S ORIGINAL BENEFIT PLAN DATE	**PLAN'S AMENDED BENEFIT PLAN DATE**	**PLAN'S ANNIVERSARY DATE**
January 1, 2017	January 1, 2017	January 1

BENEFIT PERIOD:	Calendar Year – January 1 through December 31

DEDUCTIBLE:		
	NETWORK PROVIDERS	**NON-NETWORK All Other Providers**
Benefit Period Deductible Amount - Individual:	$1,900	No Coverage
Family Deductible Amount*:	$3,800	No Coverage

* If the Benefit Plan includes more than one (1) member, the individual Benefit Period Deductible Amount is not applicable and only the Family Deductible Amount applies. No Benefits are eligible for any member of the family until the Family Deductible Amount is satisfied.

SPECIAL NOTES: The Benefit Deductible DOES NOT apply to the following:

- Office X-ray, Labs and Machine Test.
- Eligible Preventive or Wellness Care

OUT-OF-POCKET AMOUNT – Includes the Benefit Period Deductible Amount.	
Network Providers	
Individual:	$1,900
Family:	$3,800
All Other Providers (Non-Network)	
Individual:	No Coverage
Family:	No Coverage

SPECIAL NOTES:

The following accrue to the Out-of-Pocket Amount for Network Providers ONLY

- Deductible Amounts
- Coinsurance

MEDICAL BENEFITS – COINSURANCE:		
	NETWORK PROVIDERS	**NON-NETWORK** **All Other Providers**
Coinsurance shown as Company - Plan Participant responsibility.		
Deductible applies unless otherwise stated.		
Inpatient and Outpatient Facility and Professional Services for Which a Copayment is not Applicable:	100% - 0%	No Coverage
Office Visits:	100% - 0%	No Coverage
Cardiac Rehabilitation: Limited to Phase I & II and 36 visits per occurrence		
Inpatient Hospital Admission: Includes Inpatient Hospital Facility Services and Professional/Physician Charges.	100% - 0%	No Coverage
Ambulance Services:	100% - 0%	No Coverage
Ambulatory Surgical Center and Outpatient Surgical Facility: Includes Surgical Facility and Professional/Physician Charges.	100% - 0%	No Coverage
Emergency Medical Services – performed in the Emergency Department of a Hospital, Includes Facility and Professional/Physician Charges.	100% - 0%	100% - 0%
Hearing Aid: For ages 18-65, limited to $1,400 per ear every 36 months	100% - 0%	No Coverage
Home Health Care: Limited to 60 visits per Benefit Period	100% - 0%	No Coverage
Hospice Care: Limited to 60 visits per Benefit Period	100% - 0%	No Coverage
Infertility: Benefits limited to diagnosis only $1,500 lifetime max	100% - 0%	No Coverage
Mental Health and Substance Abuse Disorders:	100% - 0%	No Coverage
Organ, Tissue, and Bone Marrow Transplants: Authorization required prior to services being performed. $10,000 max per Plan Participant per lifetime.	100% - 0%	No Coverage
Pregnancy Care:	100% - 0%	No Coverage
Preventive or Wellness Care: See the “Preventive or Wellness Care” Article for more details on Preventive or Wellness Care Benefits.	100% Deductible Waived	No Coverage
Private Duty Nursing: Outpatient Services.	100% - 0%	No Coverage
X-rays, Lab Tests, Machine Tests, and High Tech Imaging:		
X-Rays, Lab Tests and Machine Tests	100% - 0%	No Coverage

High Tech Imaging – such as CT, MRI, MRA, PET, or Nuclear Cardiology.	100% - 0%	No Coverage
Rehabilitative Care Services: Limited to 60 days max combined per calendar year • Physical and Occupational Therapy • Speech Therapy	100% - 0%	No Coverage
• Chiropractic Services: Limited to 60 visits per calendar year	100% - 0%	No Coverage
Skilled Nursing Facility: limited to 60 days max per calendar year	100% - 0%	No Coverage
Temporomandibular / Craniomandibular Joint Dysfunction (TMJ): limited to max benefit $1,000 per Plan Participant per Lifetime	100% - 0%	No Coverage
Urgent Care Center:	100% - 0%	No Coverage
Wig: Coverage is available after chemotherapy, one wig per lifetime	100% - 0%	No Coverage

PRESCRIPTION DRUG COVERAGE:		
Prescription Drug Coinsurance: Applicable after Benefit Period Deductible is met. Coinsurance shown as Company-Member responsibility.	**RETAIL**	**MAIL**
Tier 1	100% - 0%	100% - 0%
Tier 2	100% - 0%	100% - 0%
Tier 3	100% -0%	100% - 0%
Tier 4	100% - 0%	100% - 0%
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 1-800-842-2015 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* (Enbrel, Remicade)		
• Intravenous immune globulin*		
• Interferons (Rebetron, Intron A, Peg-Intron)		

- Monoclonal antibodies (Synagis)
- Hyaluronic acid derivatives for joint injection* (Synvisc, Hyalgan)
  - * 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®

Compound Drugs Over $100

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

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 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 is responsible for the penalty and all charges not covered. The Plan Participant remains responsible for any applicable Deductible Amount and Coinsurance percentage.

Additional Network Provider responsibility if Authorization is not requested for Inpatient services and supplies: **10% 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.**

Non-Network Provider: **NO COVERAGE**

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
• CT Scans
• Day Rehabilitation Programs
• Electric & Custom Wheelchairs
• Home Health Care
• Hospice Care
• Hyperbarics
• Implantable Medical Devices over $2000.00, such as Implantable Defibrillator and Insulin Pump
• Intensive Outpatient Programs
• MRI/MRA
• Non-Emergency Air Ambulance
• Nuclear Cardiology
• Organ Transplant and Evaluation
• Partial Hospitalization Programs
• PET Scans
• Private Duty Nursing
• Prosthetic Appliances
• Residential Treatment Centers
• Sleep Studies, except for those done in the home
• Stereotactic Radiosurgery, including but not limited to gamma knife and cyberknife procedures
• Vacuum Assisted Wound Closure Therapy
• 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. Under no circumstances will the initial Eligibility waiting period ever exceed ninety (90) days following the date of hire.
Active Employees: The eligibility date is the first day after an Employee becomes eligible and enrolls in the Plan.