Health and Wellness
Benefit Plan Summary

Network Medical and Prescription Drug Deductibles
The deductible is the amount paid by the member for medical services or prescription drugs before the benefit plan begins to pay. A co-pay, or co-payment, is the specified amount a member pays for a covered service, usually at the time the service is received. Co-insurance is the member’s share of the cost for certain covered services once the deductible is met. “Out-of-pocket” refers to the money a member pays out of their own pocket when receiving medical care (i.e. visiting a doctor or filling a prescription) and includes deductibles, co-payments and co-insurance for covered services rendered by Network Providers. The benefit plan has a limit on the total out-of-pocket costs a member pays in a benefit year. This is referred to as the out-of-pocket maximum.

This benefit plan has separate medical and prescription drug deductibles that must be met before benefit plan payment begins. Deductibles do not apply where there is a co-pay amount, except in the case of category 2, 3 and 4 prescription drugs and the non-emergency room co-payment. Network co-pay amounts do not accrue toward the medical deductible amount but do count toward the out-of-pocket maximum. Non-network benefits do not accrue towards the out-of-pocket maximum.

Out-of-State Services
Prior authorization must be obtained by the Network Provider for non-emergent elective services provided outside the State of Mississippi unless the member resides out-of-state.

Healthy You! Wellness Benefit and Preventive Health Services
Our Healthy You! wellness benefit is designed to facilitate a healthy provider-patient relationship through annual wellness visits with a Mississippi Primary Care Network Provider. The Healthy You! benefit is provided at no out-of-pocket cost when rendered by a Healthy You! Network Provider located and practicing in Mississippi. Services must be provided in the provider’s clinical setting. The Healthy You! benefit is not covered for non-network providers or out-of-state providers (out-of-state exceptions apply to members residing outside of the State of Mississippi). See the Healthy You! Wellness Guide located at www.bcbsms.com for details on covered screenings.

Other Preventive Health Services as outlined in our medical policy are also available to covered members when rendered by a Network Provider. Visit www.bcbsms.com to view our medical policy.

Prescription Drugs
• Benefits will only be provided for drugs included in the Company’s Prescription Drug, Maintenance Drug, or Disease Specific Drug Formulary. Covered members can identify covered prescription drugs using the search feature on the My Rx tab of our myBlue member portal available at www.bcbsms.com.
• The most cost-effective drugs are in category 1 and are not subject to the prescription drug deductible.
• Benefits for prescription drugs are subject to quantity limits. No benefits will be provided for prescription drugs prescribed or dispensed beyond the quantity limits. Certain prescription drugs are subject to clinically-appropriate duration of use restrictions based upon the usual course of treatment.

• If a generic equivalent prescription drug is available but the member purchases a brand name, the member will be responsible for the entire cost of the drug.

• Certain prescribed drugs that have a generic alternative may be subject to a trial usage of a generic alternative drug for a specific period of time before benefits will be available for the prescribed drug.

• Subject to prior authorization, benefits may be available for category 4 prescription drugs where a lower cost alternative is available. If benefits are provided, the benefits will be no greater than the benefit for the lowest cost alternative.

Maintenance Drugs
Members can receive a 90-day supply of certain drugs from a Community PLUS Maintenance Pharmacy. Covered members can identify eligible medications using the search feature on the My Rx tab of our myBlue member portal available at www.bcbsms.com.

Disease Specific Drugs
Drugs must be provided by a Network Disease Specific Pharmacy or a member’s Non-Pharmacy Network Provider, be authorized in advance by the Company and listed in the Disease Specific Drug Formulary. Benefits are provided after a member co-insurance of 10% of the allowable charge up to a $200 co-pay with a minimum $100 co-pay.

Center of Excellence/Specialty Care Designated Providers
Certain specified specialty services must be rendered by a Center of Excellence Provider or a Specialty Care Designated Provider for a member to receive the highest level of benefits. Please refer to the Health and Wellness Benefit Plan Booklet to learn more about Centers of Excellence.

Blue Health Management
Our Health and Wellness Team works with the treating Network Provider to ensure the necessary care is provided in the most clinically-appropriate, cost-effective setting, to include Centers of Excellence. With Blue Health Management, eligible members, based on their health risks, have the opportunity to enroll in enhanced health management programs such as Color Me Healthy!. When enrolled in a program, certain covered outpatient services must be rendered by a designated Network Provider in order to receive benefits.

Hospital Services
Hospital services include inpatient and outpatient hospital services. Services do not include specialty services provided by a Center of Excellence Network Provider or Specialty Care Designated Network Provider.

Emergency Room (ER) Services
Emergency room services are available for medical emergencies. If a member receives non-emergency services from an emergency room, an additional co-pay will apply.
Physician and Allied Professional Services
Physician and allied professional services includes office visits and covered services in the inpatient and outpatient setting.

Other Covered Services, Supplies or Equipment
Other covered services, supplies or equipment provided by an Allied Provider or Physician are subject to Network and Non-Network Benefits, where applicable, including:

- Allergy Injections/Testing Services
- Ambulance Services
- Diagnostic Services Facility*
- Dialysis Treatment*
- Durable Medical Equipment*
- Hospice Care*
- Independent Laboratory*
- Infusion Services*
- Orthotic Devices
- Outpatient Cardiac Rehabilitation*
- Physical Medicine*
- Prosthetic Appliances
- Sleep Studies*
- Speech Therapy
- Therapy Services*

*Benefits are only available when provided by a Network Provider.

Nervous/Mental and Substance Abuse Care
- Inpatient Care
- Partial Hospitalization
- Outpatient Hospital Visits
- Other Outpatient Physician and Allied Provider Services
- Network Physician and Allied Provider Office Visits (subject to the co-pay amount)

Organ and Tissue Transplant Benefits
Prior approval and care management are required for renal transplants, other solid organ transplants (liver, heart, lung), tissue transplants (bone marrow transplants) and donor benefits. Benefits are only available when provided by an approved Network Provider.

Pediatric Vision
Pediatric vision benefits are available for members up to age 19. Benefits include an annual comprehensive routine eye exam and eyeglasses.

Pediatric Dental
Pediatric dental benefits are available for members up to age 19. Benefits include preventative and diagnostic dental care as well as certain surgical dental services. This benefit will pay primary to any other dental coverage provided by the Company.

This summary of the Health and Wellness Benefit Plan is designed for the purpose of presenting general information about the Health and Wellness Benefit Plan and is not intended as a guarantee of benefits. All services covered in this Health and Wellness Benefit Plan are subject to Medical Policy and Medical Necessity review to determine if the services are covered under this Health and Wellness Benefit Plan. This is not a Summary Plan Description and in the event of a conflict between this document and the actual Health and Wellness Benefit Plan, the terms of the Health and Wellness Benefit Plan will prevail.