MISSISSIPPI

Blue Care Group Outline of Benefits

Co-pay Option - Separate Medical and Prescription Drug Deductible

Outline of Benefits		
Benefit Period	Calendar Year	
Maximum Out-of-Pocket and Coinsurance Options		
	Network Provider	**Non-Network Provider**
Calendar Year Maximum Out-of-Pocket (including Deductible) After the Calendar Year Maximum Out-of-Pocket is met, applicable in-network expenses are covered at 100% for the remainder of the calendar year.	**Individual:** $1,100; $5,600 $6,200; $7,000; $9,200 **Family**: 2 times the Individual Amount	Not applicable for services rendered by Out-of-Network Providers
Coinsurance Options	90%, 80%, or 70%	50%
Deductible Options		
Calendar Year Medical Deductible Options	**Individual:** $650; $850; $1,000; $1,250; $2,300; $2,750; $3,000; $3,500; $3,750; $5,400 **Family:** 2 times the Individual Amount	**Individual:** 2 times the Network Amount **Family:** 2 times the Non-Network Individual Amount
Calendar Year Prescription Drug Deductible Options	$100; $200; $250; $300	
Health & Wellness		
Covered Services	***Healthy You!* Network Provider**	**Non-Network Provider**
Healthy You! Wellness Services based on age and gender. For a complete listing of the *Healthy You!* screening guidelines, visit the visit the *Healthy You!* page. Other Preventive Health Services as outlined in Medical Policy are also covered.	**100%** with no co-pay, coinsurance or deductible.	Not covered
Covered Services	**Color Me Healthy! Network Provider**	**Non-Network Provider**
Color Me Healthy! Outpatient Services for eligible Members enrolled in the Color Me Healthy! Benefit.	100%	Not Covered

Diabetes Treatment **Equipment, supplies for monitoring of blood glucose and insulin administration** Home glucose monitors limited to 1 every 2 calendar years. Prescription Drug Benefits will be provided for diabetic supplies (blood testing, urine testing, and lancets). **Self-Management Training** - six (6) hours per calendar year. **Dilated Eye Exam** - one exam per calendar year. **Preventive Routine Foot Care** - one visit per calendar year.	Coinsurance Deductible Applies	Not Covered

Prescription Drugs

Benefits are provided for Prescription Drugs included in the Prescription Drug Formulary and Maintenance Formulary.

be RxSmart. it's your choice.sm	**Community PLUS Pharmacy**	**Non-Community PLUS Pharmacy**
Category 1-Generally includes low-cost generic and some brand name drugs.	$10 Prescription Drug Deductible Waived	Not Covered
Category 2-Generally includes higher-cost generic and many brand-name drugs.	$25 or $35	Not Covered
Category 3-Generally includes some brand-name drugs and some generic drugs. These drugs may have generic or brand-name alternatives in Category 1 or 2.	$50 or $75	Not Covered
Category 4-Generally includes high cost generic drugs, high cost technology drugs and specialty drugs.	$100	Not Covered
Maintenance Medications (90-day supply) Must use Community PLUS Maintenance Pharmacies	Generic Medications: 2.5 times the Co-pay amount Brand Medications: 3 times Co-pay amount	Not Covered
Generic Only	Certain brand name or Reference Biologic Medications will not be covered if there is an available generic equivalent, Interchangeable Biological Product or Biosimilar Product.	Not Covered

Generic First	Certain prescribed medications with generic, Interchangeable Biological Product, Biosimilar Product or lower cost alternative may only be covered if the generic alternative, Interchangeable Biological Product or Biosimilar Product is prescribed first.	Not Covered
Disease Specific Drugs		
	Network Provider	**Non-Network Provider**
Drugs must be provided by a Network Disease Specific Pharmacy or a Member's Non-Pharmacy Network Provider, have been Prior Authorized by the Company, and listed in the Disease Specific Drug Formulary	Per 30-day supply, 100% after 10% of the Allowable up to a $350 co-pay with a minimum $100 co-pay.	Not Covered
Medical Specialty Drugs		
	Network Provider	**Non-Network Provider**
Drugs must be dispensed or administered by a Hospital, Physician or Allied Provider and listed in the Medical Prescription Drug Formulary. Medical Deductible applies. *Non-Network Benefits vary according to place of service. No Benefits will be provided if the Non-Network Provider's services are not covered.	Coinsurance Deductible Applies	50% Deductible Applies or Not Covered*
Specialty Services		
Specialty Services include but are not limited to: Cardiac Care; Spine Surgery; and Orthopedic Services. All Specialty Services are subject to prior authorization, a determination by Blue Cross & Blue Shield of Mississippi of the most clinically appropriate setting, and are only covered at the higher benefit level if performed by a Center of Excellence Provider or Blue Specialty Network Provider.		
Blue Specialty Network Provider*	**Non-Blue Specialty Network Provider**	**Non-Network Provider**
Coinsurance +10% Deductible Applies	Coinsurance -10% Deductible Applies	Not Covered
*Services include certain Specialty Services which are Ambulatory Services performed in a non-hospital setting approved and designated by Blue Cross & Blue Shield of Mississippi. To be covered, certain Specialty Services to include hip, knee and shoulder replacement and spine surgeries, must be provided by a Blue Specialty Network Provider.		
Center of Excellence Provider**	**Non-Center of Excellence Network Provider**	**Non-Network Provider**

Coinsurance +10% Deductible Applies	Coinsurance -10% Deductible Applies	Not Covered
**Only certain Specialty Services are covered in the Hospital Inpatient or Outpatient settings and only if supported by Medical Policy, including Medical Necessity, and a determination by the Company of the most clinically appropriate setting.		
Hospital Services		
Covered Services	**Network Provider**	**Non-Network Provider**
Inpatient Hospital Services	Coinsurance Deductible Applies	50% Deductible Applies
Outpatient Hospital Services	Coinsurance Deductible Applies	50% Deductible Applies
Emergency Room Services - Non-emergent services are subject to additional co-pay and the Non-Network Provider Coinsurance amount.	Coinsurance Deductible Applies	Coinsurance Deductible Applies
Newborn Well Baby Care - Exams and routine hospital nursery care of a well newborn.	Coinsurance Deductible Applies	50% Deductible Applies
Ambulatory Facility Services		
Ambulatory Surgical Facility Services	Coinsurance Deductible Applies	50% Deductible Applies
Physician and Allied Professional Services		
Covered Services	**Network Provider**	**Non-Network Provider**
Physician and Allied Professional Office Visit Co-pay Options	**Primary Care:** $15; $25 or $30; **Specialist:** $25; $40; $50	50% Deductible Applies
Physician Office Services (MD or DO) **Office Visits Only**	100% after Co-pay Deductible Waived	50% Deductible Applies
Other Physician Office Services Includes, but not limited to injections, x-ray/lab and other services. Does not include Durable Medical Equipment, Prosthetics or Orthotic Devices.	Coinsurance Deductible Waived	50% Deductible Applies
Allied Primary Care Health Professional (Certified Nurse Practitioner, Certified Nurse Midwife, Physician Assistant) **Office Visits Only**	100% after Co-pay Deductible Waived	50% Deductible Applies

Other Allied Office Services Includes, but not limited to injections, x-ray/lab and other services. Does not include Durable Medical Equipment, Prosthetics or Orthotic Devices.	Coinsurance Deductible Waived	50% Deductible Applies
Allied Specialist Office Visits Only* **	100% after Co-pay Deductible Waived	50% Deductible Applies
Other Office Services* **	Coinsurance Deductible Waived	50% Deductible Applies
***When Physical Medicine services are provided, Benefits are limited to 20 visits per calendar year and 3 modalities per visit. The limit applies to visits in the home or at the Allied Specialist's office or facility. Benefits are not provided for Physical Medicine Services provided by Non-Network Providers. Services provided by Non-Network Physical Therapists, Occupational Therapists and/or Chiropractors are not covered.		
Other Allied Services		
	Network Provider	**Non-Network Provider**
Ambulance Services, Allergy Injection/Testing	Coinsurance Deductible Applies	50% Deductible Applies
Diagnostic Services Facility, Dialysis Treatment, Durable Medical Equipment, Independent Laboratory, Infusion Therapy, Outpatient Cardiac Rehabilitation, Sleep Studies	Coinsurance Deductible Applies	Not Covered
Hospice Care Limited to 6 months per lifetime, subject to Care Management	Coinsurance Deductible Applies	Not Covered
Habilitative Care Limited to 20 Physical Therapy and Occupational Therapy visits, combined, and 20 Speech Therapy visits per calendar year.	Coinsurance Deductible Applies	Physical Therapy and Occupational Therapy: Not Covered Speech Therapy: 50%, Deductible Applies
Physical Medicine - Limited to 20 visits per calendar year and 3 modalities per visit. The limit applies to visits in the home or at the Allied Specialist's office or facility.	Coinsurance Deductible Applies	Not Covered
Prosthetics and Orthotic Devices	Coinsurance Deductible Applies	Coinsurance Deductible Applies
Speech Therapy - Limited to 20 visits per calendar year.	Coinsurance Deductible Applies	50% Deductible Applies
Therapy Services - Includes chemotherapy, gene therapy, immunotherapy, radiation and respiratory therapy.	Coinsurance Deductible Applies	Not Covered

Mental Health and Substance Use Disorder Services		
	Network Provider	**Non-Network Provider**
Inpatient Care	Coinsurance Deductible Applies	50% Deductible Applies
Partial Hospitalization	Coinsurance Deductible Applies	50% Deductible Applies
Hospital Outpatient Visits	Coinsurance Deductible Applies	50% Deductible Applies
Other Outpatient Physician and Allied Professional Services	Coinsurance Deductible Applies	50% Deductible Applies
Physician and Allied Professional Office Visits	100% after Co-pay Deductible Waived	50% Deductible Applies
Other Services Rendered in Physician and Allied Professional's Office	Coinsurance Deductible Waived	50% Deductible Applies
Pediatric Dental and Vision Services		
Pediatric dental and vision benefits are available for members up to age 19.		
Pediatric Dental		
Preventive and Diagnostic Services	Coinsurance Deductible Waived	Coinsurance Deductible Waived
Other Dental Services (as defined within the Benefit Plan)	50% Deductible Waived	50% Deductible Waived
Pediatric Vision		
Routine Eye Exam	100% after Co-pay Deductible Waived	Not Covered
Eyeglasses - One pair per year, subject to limitations within the Benefit Plan.	100% up to $150 Deductible Waived	Not Covered

This summary of the Blue Care Group Benefit Plan is designed for the purpose of presenting general information about the Benefit Plan and is not intended as a guarantee of benefits. It is not a Summary Plan Description and in the event of a conflict between this document and the actual Benefit Plan, the terms of the Benefit Plan will prevail. All services are subject to Medical Policy and Care Management.