BlueCross BlueShield of Mississippi

# Network Blue Health and Wellness Benefit Plan Summary

**This Network Blue Health and Wellness Benefit Plan summary 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 referenced in the Health and Wellness Benefit Plan are subject to Medical Policy and Medical Necessity review to determine if the services are covered. This is not a Summary Plan Description. 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.**

| BENEFIT PLAN YEAR | CALENDAR YEAR |
|---|---|
| DEDUCTIBLE AMOUNTS | |
| Individual Medical Deductible | $500 |
| Family Maximum | $1,000 |
| Prescription Drug Deductible | $0 |
| The Deductible does not apply where there is a Co-payment amount. Co-payment amounts do not accrue toward the Medical Deductible Amount but do accrue to Network Out-of-Pocket amount. | |
| OUT-OF-POCKET MAXIMUM for a Network Provider | |
| Individual | $2,500 |
| Family | $5,000 |
| NETWORK PROVIDER BENEFITS | |
| (Subject to the Allowable) | 80% |
| NON-NETWORK PROVIDER BENEFITS | |
| (Subject to the Allowable) | 60% |

- All services are subject to the Network Provider and Non-Network Provider Benefits

HEALTHY YOU! PREVENTIVE HEALTH SERVICES - See the *Healthy You!* Preventive Health Services Age and Gender Guidelines located at www.bcbsms.com. Benefits for covered screenings are provided at 100% at no out-of-pocket cost. Services must be rendered by a Network Provider approved by the Company in that Provider's clinical setting. Members with a Blue Primary Care Home will receive Healthy You! Covered Services from their selected Blue Primary Care Network Provider or Pediatric Blue Primary Care Network Provider. Not covered at Non-Network Providers.

HOSPITAL SERVICES - Includes Inpatient and Outpatient Hospital Services, which are not those services included under the Specialty Services provisions. Only certain Covered Services will be covered in a Hospital setting. Prior Authorization may be required to determine the most clinically appropriate setting.

EMERGENCY ROOM (ER) SERVICES - See special information related to ER Services included in your Health and Wellness Benefit Plan found in the *my*Blue portal at www.bcbsms.com.

AMBULATORY SURGICAL FACILITY SERVICES (ASF)
Prior Authorization for Ambulatory Surgical Facility Services may be required if the Covered Service can be provided in a lower place of treatment (i.e. office.)

| PHYSICIAN SERVICES (M.D. and D.O. only) | Primary Care | Specialist | Non-Network Provider |
|---|---|---|---|
| • Office Visit | 100% after $15 Co-pay | 100% after $25 Co-pay | 60% |

(Co-pay does not apply to any other services rendered in the office. Other Services rendered in the Physician's Office are subject to the Benefit amounts.)

- Surgery (Hospital/ASF)
- Medical (Inpatient)
- Diagnostic Services

ALLIED PRIMARY CARE HEALTH PROFESSIONAL (Certified Nurse Practitioner, Certified Nurse Mid-wife and Physician Assistant)

| | Network Provider | Non-Network Provider |
|---|---|---|
| • Office Visit | 100% after $15 Co-pay | 60% |

(Co-pay does not apply to any other services rendered in the office. Other Services rendered in the Office are subject to the Benefit amounts.)

SPECIALTY SERVICES – Certain specified Specialty Services must be rendered by a Center of Excellence Provider or a Blue Specialty Network Provider for you to receive Benefits. Please refer to your Health and Wellness Benefit Plan to learn more about Specialty Services.

PRESCRIPTION DRUGS
- Prescription Drug Deductible does not apply to Category 1 drugs.
- No Benefits will be provided for any drug not included in the Company's Prescription Drug, Maintenance Drug, or Disease Specific Drug Formulary.

| | Community PLUS Pharmacy | | Non-Community PLUS Pharmacy |
|---|---|---|---|
| Category One Drugs | $10 | Co-pay | No Benefits |
| Category Two Drugs | $25 | Co-pay | No Benefits |
| Category Three Drugs | $50 | Co-pay | No Benefits |
| Category Four Drugs | $100 | Co-pay | No Benefits |

MAINTENANCE DRUGS – Members can receive a 90-day supply of certain drugs from a Community PLUS Maintenance Pharmacy. Refer to the Health and Wellness Benefit Plan for more information.

DISEASE SPECIFIC DRUGS - Drugs must be provided by a Network Disease Specific Pharmacy or a member's Non-Pharmacy Network Provider, authorized in advance by the Company, and listed in the Disease Specific Drug Formulary. This Benefit is covered after 10% of the Allowable up to a $350 Co-pay with a minimum $100 Co-pay.

GENERIC DRUGS
- If a generic equivalent Prescription Drug, Interchangeable Biological Product or Biosimilar Product is available but the member purchases a brand name or Reference Biologic Medication, the member will be responsible for the entire cost of the drug.
- Certain brand name drugs included in the applicable Drug Formulary that have a generic alternative, Interchangeable Biological Product or Biosimilar Product may be subject to a trial usage of a generic alternative drug, Interchangeable Biological Product or Biosimilar Product for a specific period of time before Benefits will be available for the prescribed drug.

MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS – Covered services are subject to Deductible, Co-pay and Network or Non-Network Co-insurance.

ORGAN AND TISSUE TRANSPLANT BENEFITS – Renal Transplants, Other Solid Organ Transplants (Liver, Heart, Lung), Tissue Transplants (Bone Marrow Transplants) and Donor Benefits. Prior Approval and Care Management required. Covered Services must be provided by a Network Provider approved and designated by Company for the particular transplant surgery. Travel and lodging Benefits may be available subject to the Travel and Lodging Reimbursement Policy.

NEWBORN WELL BABY CARE - Subject to the Network and Non-Network Benefit amounts, Benefits for a newborn covered as a Dependent include subsequent visits while in the Hospital with the mother, circumcision and discharge of baby

COLOR ME HEALTHY! – As part of our continued commitment to your health and wellness, you have the option to enroll in the Color Me Healthy! Benefit that focuses on the treatment and control of metabolic health risks and diseases. Once you enroll in this program, certain covered outpatient services must be rendered by a Color Me Healthy! Network Provider in order to receive Benefits. Members with a Blue Primary Care Home will receive Color Me Healthy! Covered Services from their selected Blue Primary Care Network Provider.

OTHER COVERED SERVICES, SUPPLIES OR EQUIPMENT PROVIDED BY AN ALLIED PROVIDER OR PHYSICIAN
- 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 not available unless provided by a Network Provider.

**There are important details that are not included in this summary about covered services, prior authorization requirements, benefit limits and services that are not covered. You can find these details in your Health and Wellness Benefit Plan online through the *my*Blue portal at www.bcbsms.com. There, you can read the plan online or print a copy.**