BlueCard® Program

BlueCard® is a national program offered through the Blue Cross and Blue Shield Association, an association of independent, locally owned Blue Cross and Blue Shield companies that enables participants to obtain network health care services while traveling or living outside of Mississippi. Through BlueCard®, participants have access to a national network of Blue Cross and Blue Shield contracted health care providers.

Participants have access to the BlueCard® Program across the country. This seamless program affords participants the ability to use any Blue Cross and Blue Shield (BlueCard®) network providers in any location.

Medical Case Management/Utilization Review

Acentra Health (Acentra), formerly known as Keystone Peer Review Organization, Inc. (Kepro) is the medical management administrator for the Plan. Acentra provides medical management, case management and utilization review services. Utilization review is a process to ensure medical services are medically necessary, delivered in the most appropriate setting, reflective of the correct length of stay, and consistent with generally accepted medical standards. Certification requirements may apply, regardless of whether a participant uses a network or out-of-network provider.

Certification is not required for those participants having Medicare for their primary coverage or other primary coverage, unless the primary carrier does not cover the service. For additional information on services requiring certification, participants can reference of the *Medical Case Management and Utilization Review* section of the Plan Document or access the information on the Plan's website at https://www.dfa.ms.gov/insurance.

Health and Wellness Program/Chronic Condition Coaching

ActiveHealth Management, Inc. (ActiveHealth) is the Plan's vendor for health and wellness management. ActiveHealth provides resources to enhance the physical, emotional, and social well-being of Plan participants and provides chronic condition education & coaching designed to support and guide Plan participants on how to lead healthier lives. ActiveHealth provides an engaging, user-friendly, and interactive telehealth portal for managing the Plan's health and wellness program via the Motivating Mississippi – Keys to Living Healthy website and through a smart-phone app available for Apple® and Android cellphones.

Motivating Mississippi – Keys to Living Healthy

Motivating Mississippi – Keys to Living Healthy is the Plan's health and wellness promotion program. It is designed to help participants achieve and maintain a healthy lifestyle and reach their wellness goals. Participants can access this program through the Plan's website at https://www.dfa.ms.gov/insurance.

Participants with certain chronic conditions may enroll in a disease management program administered by ActiveHealth. The program provides help, support and education for participants living with diseases such as cardiac disease, asthma, and/or diabetes. The program is voluntary, completely confidential and provided at no cost to participants.

Special features of the program include:

- Personalized telephonic counseling about the participant's specific health condition.
- Helping the participant achieve health goals.
- An individualized care plan for nutrition, exercise and other lifestyle needs.
- Educational materials.
- Access to community resources.
- Access to health and medical topics.

This program does not replace care rendered by the participant's provider. For information on this program or to stop participation in the program, contact ActiveHealth at 866-939-4721.

ActiveHealth uses its CareEngine® Clinical Decision Support program to identify clinical issues that providers and patients can discuss. ActiveHealth continually monitors medical and pharmacy claims. If the program identifies drug interactions or other medical issues, the participant and his provider will receive a letter called a Care Consideration.

Pharmacy Benefit Manager

CVS Caremark is the pharmacy benefit manager (PBM) for the Plan's prescription drug program. CVS Caremark is responsible for processing prescription claims received from network pharmacies, mail order claims, and paper claims filed directly by participants. To find the most cost-effective place to purchase prescription drugs, participants should visit www.caremark.com. CVS Caremark provides a prescription drug identification card which should be presented when purchasing prescription drugs. For a new or replacement identification card, participants should contact CVS Caremark.

NOTE: Medicare eligible retirees, Medicare eligible surviving spouses and Medicare eligible dependents of retirees and surviving spouses are not eligible for prescription drug benefits.

Telehealth Provider Visits

The University of Mississippi Medical Center (UMMC) is the preferred telehealth provider for the Plan. UMMC provides access to providers for participants, Monday through Friday from 8:00am to 5:00pm, to receive health care using a smartphone, tablet or webcam-enabled computer to access their UMMC 2 You website at www.umc.edu/Healthcare/Telehealth or through their free UMMC 2 You app. For questions about UMMC 2 You, email Telehealth@umc.edu or call 601-815-2020. Other network providers may be eligible to render telehealth provider visits.

Base Coverage

Base Coverage is a qualifying high deductible health plan that meets the federal government's criteria under Section 1201 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 in regard to establishing a Health Savings Account (HSA). HSAs are portable, interest-bearing, funded accounts that provide for tax-free savings for medical expenses. HSAs allow individuals to pay for current qualified medical expenses and save for future qualified medical expenses on a tax-free basis. The Plan does not offer or administer HSA accounts. However, participants in Base Coverage may refer to their agency to secure an HSA.

Summary of Base Coverage Benefits

This is only a summary of the benefits under Base Coverage. It does not provide all details and provisions of the Plan. Some limitations and exclusions apply and can be found within this *Plan Document*. All benefits are subject to the calendar year deductible unless otherwise noted in the *Covered Services* section. There are two tiers of coverage: Individual and Family.

Individual Coverage	**Network**	**Out-of-Network**
Calendar Year Deductible	$1,800	
Preventive Medications Deductible (Other medications are subject to Calendar Year Deductible)	$75	
Coinsurance Maximum	$3,000	$4,000
Out-of-Pocket Limit	$6,500	N/A
Family Coverage	**Network**	**Out-of-Network**
Calendar Year Deductible	$3,400	
Preventive Medications Individual Deductible (Other medications are subject to Calendar Year Deductible)	$75	
Coinsurance Maximum	$5,500	$7,500
Out-of-Pocket Limit (In no event shall any one individual with family coverage exceed $6,500 out-of-pocket expenses for covered network expenses.)	$13,000	N/A
Telehealth Minor Medical Care Visit	You pay $10 copayment subject to deductible	Not Covered
Telehealth Dietitian Services Visit	You pay $10 copayment subject to deductible	Not Covered
Telehealth Mental Health Care Visit	You pay 20%	Not Covered
Specialty Physician/Health Care Professional Services	You pay 20%	You pay 40%
Inpatient Hospital – Services must be certified as medically necessary by Acentra to be covered by the Plan (except for routine maternity delivery).	You pay 20%	You pay 40%
Outpatient Hospital Services	You pay 20%	You pay 40%
Emergency Room – Services are subject to a $50 copayment for the first visit and a $200 copayment for each subsequent visit in addition to the deductible and coinsurance. Copayment is waived if admitted.	You pay 20%	You pay 20%
X-Rays, Laboratory	You pay 20%	You pay 40%

Outpatient MRI/MRA/CAT/CTA Scans	You pay 20%	You pay 40%
Adult Wellness/Preventive Services	Plan pays 100%	Not Covered
Maternity – Specified prenatal care and network routine physician delivery covered at 100% subject to completion of the Maternity Management Program. *Note: Benefits are limited for dependent children.*	You pay 20%	You pay 40%
Maternity – Hospital; Other Services *(Not available for dependent children.)*	You pay 20%	You pay 40%
Well-Newborn Nursery Care	Plan pays 100%	Not Covered
Well-Child Office Visits and Routine Tests	Plan pays 100%	Not Covered
Well-Child Routine Immunizations	Plan pays 100%	Not Covered
Chiropractic Services – Manipulative therapy services - Limited to a maximum of 30 visits per participant per calendar year.	You pay 20%	You pay 40%
Accidental Injury to Natural Teeth and TMJ Services – Coverage is subject to the network coinsurance/copayment maximum. TMJ services are limited to a lifetime maximum of $5,000.	You pay 20%	You pay 20%

Participants in the Base Coverage will be charged the full allowable amount until the applicable deductible is met. Prescription medications are subject to the applicable deductible and the following copayments:

	Retail & Specialty Pharmacies			**Home Delivery**
Prescription Drug Type	**1-30 Day Supply**	**31-60 Day Supply**	**61-90 Day Supply**	**90 Day Supply (or less)**
Preferred Generic Drug	$12	$24	$36	$24
Non-preferred Generic Drug	$30	$60	$90	$60
Preferred Brand Drug*	$45	$90	$135	$90
Non-preferred Brand Drug*	$100	$200	$300	$200
Specialty Drug	$100	N/A	N/A	N/A

***Generic mandate applies to brand drugs purchased when a generic is available.** If a participant purchases a covered brand drug for which a generic equivalent is available, the participant will pay the difference in the cost of the brand and the generic drug, plus the applicable brand copayment amount.

Individual Preventive Medications Deductible

Certain preventive medications such as anticoagulants, antiarrhythmics, antihyperlipidemics, antidepressants and diabetes medications are only subject to the preventive medications deductible. If the Base Coverage calendar year deductible is already met, a participant does not also have to meet the preventive medications deductible. Once either deductible is met, participants will pay the standard prescription drug copayments for certain preventive medications, see *Prescription Drug Program*.

Diabetes Related Prescriptions and Supplies Copayments	Retail Pharmacies			Diabetic Management Program
	1-30 Day Supply	31-60 Day Supply	61-90 Day Supply	90 Day Supply (or less)
Testing Supplies:				
Preferred Brand	$12	$24	$36	$24
Non-preferred Brand	$45	$90	$135	$90
Insulin Needles/Syringes	$12	$24	$36	$24
Glucagon	$12	$24	$36	$24
Insulin	$12	$24	$36	$24

Calendar Year Deductible – Individual Base Coverage

The calendar year deductible is the amount of covered expenses a participant must pay each year before the Plan begins to pay its share of covered expenses. Covered medical and prescription drug expenses apply toward the calendar year deductible, unless otherwise indicated. Once the calendar year deductible has been met, the Plan pays its portion of the allowable charge for covered expenses, and the participant pays prescription drug copayments for covered prescription drugs and a percentage of the allowable charge for covered medical expenses.

Calendar Year Deductible – Family Base Coverage

Family coverage applies when an enrollee (active employee, retiree, surviving spouse or COBRA participant) has one or more covered dependents. If an enrollee has family coverage, there is no separate high deductible for each covered individual in the family. Covered medical and prescription drug expenses apply toward the family calendar year deductible, unless otherwise indicated. Medical services and prescription drugs will not be paid for any participants in the family until the family deductible has been satisfied. However, in no event shall an individual's annual out-of-pocket costs exceed $6,500. The family deductible also applies when both husband and wife are covered separately as enrollees, one of the enrollees has dependent coverage, and both are enrolled in Base Coverage.

If both husband and wife are covered employees, one carries dependent coverage, and only one of them elects Base Coverage, calendar year deductibles and coinsurance amounts are not shared. If both husband and wife are covered employees with employee-only coverage, and both elect Base Coverage, the calendar year deductible and coinsurance amounts are not shared.

The following expenses do not count toward the individual or family calendar year deductible:

- Emergency room copayments
- Prescription drug copayments
- Utilization review penalties
- Generic drug differential amounts
- Expenses in excess of the allowable charge
- Expenses in excess of Plan maximum limits
- Pharmacy coupon assistance or 'manufacturer copay card' programs
- Services not covered by the Plan
- Services not considered medically necessary
- Telehealth provider visit copayments

Coinsurance – Base Coverage

Once the applicable deductible has been met, the Plan pays a portion of the allowable charge for covered medical expenses. The participant pays the remainder in the form of coinsurance.

Any fees charged by an out-of-network provider that are more than the allowable charge are not part of the coinsurance amount. The Plan will not pay any portion of these charges.

Do these expenses count toward the Coinsurance Maximum?

YES	NO
• Coinsurance paid for hospital inpatient services • Coinsurance paid for other covered medical expenses	• Calendar year deductible • Preventive medications deductible • Telehealth provider visit copayments • Emergency room copayments • Prescription drug copayments • Pharmacy coupon assistance or 'manufacturer copay card' programs • Generic drug differential amounts • Utilization review penalties • Expenses in excess of the allowable charge • Expenses in excess of Plan maximum limits • Services not covered by the Plan • Services not considered medically necessary

Coinsurance Maximum – Individual Base Coverage

The coinsurance maximum is the maximum amount that an enrollee with individual coverage has to pay in coinsurance for covered medical expenses in a calendar year before benefits will be paid at 100 percent of the allowable charge. The coinsurance maximum provides participants protection against catastrophic health care expenses. The amounts paid toward meeting the calendar year medical deductible, preventive medications deductible, telehealth provider visit copayments, emergency room copayments and prescription drug copayments do not count toward satisfying the coinsurance maximum.

The initial $3,000 of coinsurance is applied to both the network and out-of-network coinsurance maximum. After the initial $3,000 has been met, only the coinsurance amount for services rendered by out-of-network providers will be applied to the additional $1,000 out-of-network coinsurance. Once the annual coinsurance maximum is met, the Plan pays 100 percent of the allowable charge for covered medical expenses for the remainder of that calendar year, except as otherwise specified.

Coinsurance Maximum – Family Base Coverage

The coinsurance maximum is the maximum amount that a family has to pay in coinsurance for covered medical expenses in a calendar year before benefits will be paid at 100 percent of the allowable charge. If an enrollee has family coverage, there is no separate coinsurance maximum for each individual. The family coinsurance maximum also applies when both husband and wife are covered separately as enrollees, one of the enrollees has family coverage, and both are enrolled in Base Coverage. The amount paid toward meeting the calendar year medical deductible, preventive medications deductible, telehealth provider visit copayments, emergency room copayments, and prescription drug copayments do not count toward satisfying the coinsurance maximum.