



Network Blue Summary of Benefits City of Pass Christian

This summary is designed for the purpose of presenting general information only 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 Benefit Plan, the terms of the Benefit Plan will prevail. The terms “pay,” “paid,” “payment,” and “payable” appear throughout this Summary of Benefits. These terms reference the benefits provided by Blue Cross & Blue Shield of Mississippi (hereinafter “BCBSMS”), rather than an actual amount paid by BCBSMS. Actual benefits and the limitations, exclusions, terms, conditions and definitions to which such benefits are subject are contained in the Benefit Plan. Complete terms of the plan are contained in the Summary Plan Description.

Important Terms

Allowable Charge – The lesser of the: (1) Covered Charges or (2) the amount established by BCBSMS as the maximum amount for Provider services covered under the terms of the Benefit Plan.

Benefits – The amount provided under the Benefit Plan for covered services. Benefits are based on the Allowable Charge minus any applicable Deductible Amount, Coinsurance or Copayment.

Coinsurance - That portion of the Allowable Charge expressed as a percentage for which the Member is financially responsible under the Benefit Plan in addition to any applicable deductible and copay amounts.

Copay (Copayment) – That portion of the Allowable Charge expressed as an amount for which the Insured is financially responsible under this Benefit Plan, in addition to the Deductible Amount, where applicable.

Covered Services – A service or supply specified in the Benefit Plan for which Benefits are available when rendered by a Provider. A charge for a Covered Service is considered to have been incurred on the date the service or supply was provided to the Member.

Deductible – The amount the Member must pay each calendar year toward covered services. Medical and pharmacy deductibles are separate.

Member – A subscriber or an enrolled dependent.

Out-of-Pocket – Unreimbursable expenses incurred by a Member for Covered Services in a Benefit Period. This does not include any applicable deductible, copay or charges for non-covered services or any charges in excess of the Allowable Charge.

Precertification/Certification – A determination by BCBSMS that an admission or health care service is medically necessary as well as meets the utilization management requirements of the Benefit Plan.

Primary Care Physician (PCP) – A physician who practices under one of the following specialties: Family Practice, General Practice, Internal Medicine, Pediatrics or Obstetrics/Gynecology.

Specialist – A physician who practices under any one of a number of specialties from Allergy to Urology, not including the five specialties of Primary Care Physicians.

Your Network Blue Benefit Plan includes Network Providers such as physicians, hospitals, pharmacies, and others. To ensure that you receive the highest level of benefits, you should always use Network Providers. Some services must be provided by Primary Care Physicians (PCPs) or Primary Care Health Professionals to receive the higher level of benefits, or to be covered at all.

If you are admitted to a Non-Network Hospital, you are responsible for ensuring that your admission is pre-certified/certified. Failure to do so will result in a \$300 penalty, which you will be responsible for paying. Failing to have the admission pre-certified could result in no payment whatsoever should the treatment fail to meet all other Benefit Plan requirements, such as medical necessity.

If you have questions regarding your Benefit Plan or Network Providers, please call our Customer Service Department at 1-800-942-0278 or (601) 664-4590. For questions regarding your pharmacy benefits, please call Pharmacy Benefits Management at 1-800-551-5258 or (601) 664-4998.

The benefits described below are for general information. You should refer to your Summary Plan Description for complete details regarding benefit maximums, limitations and exclusions, pre-certification requirements and penalties and non-covered services.

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If you use Network Providers:

- You cannot be billed for any amount (other than your deductible, coinsurance or copay) over the allowable charge for covered services.
- Network Providers will file your claims for you.
- You will be responsible for paying copays as determined by your Benefit Plan.
- You will be responsible for paying any applicable deductibles, coinsurance and non-covered charges (unless otherwise noted below) as determined by your Benefit Plan.

If you use Non-Network Providers:

- You may have to pay for charges that exceed the allowable charge.
- You may have to pay the provider the full amount during the visit and file a claim for reimbursement.
- Healthy You! wellness benefits are not covered.
- You may have to pay more for your health care.
- There is no out-of-pocket limit for services from Non-Network Providers.

Your Benefit Plan includes the following:	Network	Non-Network
Lifetime Maximum	\$2,000,000	
Medical Deductible Per Calendar Year Copay amounts do not accrue toward the deductible. Network and Non-Network Deductibles are combined.	Individual: \$500 Family: \$1,500	Individual: \$500 Family: \$1,500
Prescription Drug Deductible Per Calendar Year Copay amounts do not accrue toward the deductible.	\$0 (Each member must satisfy the Prescription Drug Deductible.)	Not Covered
Out-of-Pocket Per Calendar Year Members are still responsible for copay amounts after the out-of-pocket limit has been met.	Individual: \$1,000 Family: \$3,000	Individual: No Limit Family: No Limit
Benefits/Coinsurance The member is not responsible for paying a coinsurance amount when there is a copay.	80%	60%
Physician (MD or DO) Office Visit Copay Applies to the office visit only. Copay amounts do not accrue toward the deductible.	Primary Care Physician (PCP): \$30 Specialist: 30	60% Deductible Applies
Pharmacy Copay - Community PLUS Pharmacy Network Member must satisfy Prescription Drug Deductible if applicable. For Disease Specific Drugs refer to Employee Booklet.	Varying Amounts for: Category 1: \$10 Category 2: \$25 Category 3: \$50 Category 4: \$100	Not Covered
Disease Specific Drugs Network Provider must receive Prior Authorization and medicine must be supplied by a Network Disease Specific Pharmacy or a Non-Pharmacy Network Provider	\$100 or 20% Copay, whichever is greater \$10,000 out-of pocket limit, then a \$100 Copay	Not Covered

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Covered Services	Network	Non-Network
Hospital Inpatient Services	80% / Deductible Applies	\$100 Per Admission Ded. Plus 60%/ Deductible Applies
Ambulatory Surgical Facility Services	80%/ Deductible Applies	60%/ Deductible Applies
Emergency Room Services	80%/ Deductible Applies	\$50 ER Deductible (Cal. Yr. Deductible Applies) (Network benefits apply in cases of accident or medical emergency.)
Approved Allied Services DME, Ambulance, Prosthetics/Orthotics, etc.	80%/ Deductible Applies	60%/ Deductible Applies
Diabetes Treatment - <u>Must</u> have a diagnosis of diabetes 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 (i.e., blood testing, urine testing and lancets). Self-Management Training/Education and Medical Nutrition Therapy - Limited to \$250 per calendar year. Dilated Eye Exam - 1 exam per year. Preventive Routine Foot Care - 1 visit per calendar year.	80%/ Deductible Applies	60%/ Deductible Applies
Approved Therapy Services Chemotherapy, Radiation, etc.	80%/ Deductible Applies	60%/ Deductible Applies
TMJ Lifetime Maximum: \$5,000. Covered charges do not accrue toward the out-of-pocket amount. Copays are applicable to Network Physician Office Visits.	80%/ Deductible Applies	60%/ Deductible Applies
Physical Medicine - Limited to 20 visits per calendar year; combined with Allied Specialist visits.	80% / Deductible Applies	60%/ Deductible Applies
Nervous / Mental Care Hospital Inpatient Care - Not to exceed 30 days per calendar year. Partial Hospitalization - Maximum of 60 days per calendar year. "Partial" means admission for less than 24 hours. Hospital Outpatient Visits - Maximum of 52 visits per calendar year; combined with Physician Office Visits. Other Physician Outpatient Services Physician Office Visits - Maximum of 52 visits per calendar year combined with hospital outpatient maximum. Other Services Rendered in Physician's Office	80%/ Deductible Applies 80%/ Deductible Applies 80%/ Deductible Applies 80% (Deductible Applies) 100% after Copay 80% (Deductible Waived)	60%/ Deductible Applies 60%/ Deductible Applies 50% (Deductible Applies) 50% (Deductible Applies) 50% (Deductible Applies) 50% (Deductible Applies)
Alcohol Abuse - Maximum of \$1,500 per calendar year. Covered charges do not accrue toward the out-of-pocket amount. Copays are applicable to Network Physician Office Visits.	80%/ Deductible Applies	60%/ Deductible Applies
Drug Abuse - Maximum of \$1,500 per calendar year. Covered charges do not accrue toward the out-of-pocket amount. Copays are applicable to Network Physician Office Visits.	80%/ Deductible Applies	60% Deductible Applies
Organ Transplant - No benefits provided without prior approval and case management. Transplants are subject to the lifetime maximum. Donor Benefits - Included in the Member's lifetime maximum.	80%/ Deductible Applies 80%/ Deductible Waived	Not Covered



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Covered Services	Network	Non-Network
Newborn Well Baby Care - Exams and routine hospital nursery care of a well newborn.	80%/ Deductible Applies	\$100 Per Admission Ded., plus / 60% Deductible Applies
Physician Services (MD or DO) - Other than office services.	80%/ Deductible Applies	60%/ Deductible Applies
Physician Office Services (MD or DO) Office Visits Only - Other than Preventive/Wellness. Other Office Services - Other than Preventive/Wellness. Includes injections, X-ray/lab, surgery, etc.	100% after Copay (Deductible Waived) 80% (Deductible Waived)	60%/ Deductible Applies
Healthy You! Preventive Wellness Services (Covered Services based on age and sex parameters)	100% Deductible Waived	Not Covered
Outpatient Prescription Drugs (Quantity limits may apply. Member must satisfy Prescription Drug Deductible if applicable. If Member purchases a brand Name medication with a generic equivalent, Member will pay the brand copay plus the cost difference in the brand and generic price) Category 1 Category 2 Category 3 Category 4	Community PLUS Pharmacy 100% after Copay 100% after Copay 100% after Copay 100% after Copay	Non-Community PLUS Pharmacy Not Covered
Allied Primary Care Health Professional - Nurse Practitioner/Nurse Midwife/Physician Assistants Office Visits - Copay does not apply to any other services rendered in the office. Other Office Services - Deductible does not apply to services rendered by a Network Provider.	100% after PCP Copay 80% Deductible Waived	60% Deductible Applies
Allied Specialist Limited to 20 visits per calendar year for physical medicine services from chiropractors, physical therapists and occupational therapists. Office Visits - Copay does not apply to any other services rendered in the office. Other Office Services - Deductible does not apply to services rendered by a Network Provider.	100% after Specialist Copay 80% Deductible Waived	60%/ Deductible Applies
Hospice Care Limited to 6 months lifetime benefit subject to case management.	80% / Deductible Applies	Not Covered

Blue Cross & Blue Shield of Mississippi (hereinafter "BCBSMS") has entered into payment agreements with hospitals to provide services to persons entitled to hospital benefits under Blue Cross & Blue Shield of Mississippi benefit plans. Under these agreements, BCBSMS does not always pay an amount to the hospital which corresponds to the benefit amount. The payment made by BCBSMS, together with the Member's deductible, coinsurance, and/or copayment, may be greater than or less than covered charges. Any savings as a result of these payment agreements are utilized in the financing of the Benefit Plan. A Member's coinsurance is based on the lesser of covered charges or the amount established by BCBSMS as the maximum amount for services covered under the terms of the Benefit Plan.