YOU. YOUR HEALTH. YOUR LIFE.

BlueCross BlueShield
of Mississippi

Blue Care Group

Introduction

This booklet provides the information you need regarding your group Benefit Plan. Take time to familiarize yourself with the “Schedule of Benefits” and “Definitions” sections, then refer to the following specific sections for further information and explanation:

- Schedule of Eligibility: This section explains who is covered under your Benefit Plan, when your coverage begins, and how and when to change your coverage.
- Benefits Provided: This section contains information about Covered Services.
- Limitations and Exclusions: This section lists Benefit limitations and services that are not covered under this Benefit Plan.
- General Provisions: This section includes information about Coordination of Benefits, Termination of Coverage, Payment of Benefits, Benefit Plan Changes and Certified Agent’s Limitation of Authority.

If you have questions regarding your Benefit Plan, please contact our Health and Wellness Team at 601-664-4590 or 800-942-0278 between 8:00 a.m. and 4:30 p.m., Monday through Friday. TTY/TDD services are available by dialing 711 or 1-800-582-2233. A Mississippi Relay Operator will get in touch with Blue Cross & Blue Shield of Mississippi to help with your needs.

If you are a limited English or non-English speaker, the Company provides language services to allow you to obtain information about your Benefits and medical services. To access these language services, please contact our Health and Wellness Team at 601-664-4590 or 800-942-0278 and they can assist you through an interpreter.

Si usted no habla Inglés o habla poco Inglés, la Compañía ofrece servicios lingüísticos que le permiten obtener informacíon sobre sus beneficios y servicios médicos. Para acceder estos servicios de idiomas, por favor póngase en contacto con nuestro equipo de Bienestar y Salud al 601-664-4590 o 800-942-0278 para obtener ayuda a través de un intérprete.

GLOBAL OUTREACH
Summary Plan Description
Blue Care Group

GROUP NUMBER 078391

® Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company, a member of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans.

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Important Information

Plan Name

GLOBAL OUTREACH
Employee Health Benefit Plan

Plan Sponsor

GLOBAL OUTREACH
74 Kings Highway
Pontotoc,MS 38863
662-842-4615

Plan Administrator

MARSHALL LECROY

Named Fiduciary

GLOBAL OUTREACH

Agent for Service of Legal Process

JOHN DARNELL

Employer Identification Number

481256219

Plan Number

501

Type of Plan

Welfare Benefit Plan

Effective Date of Plan

01/01/2026

Plan Year Ends

12/31

Plan Costs

Contributory

Department of Labor Office

Department of Labor
61 Forsyth Street, Suite 7B54
Atlanta, GA 30303
(404) 302-3900
(866) 487-2365 - Washington, DC Office

Contact the Department of Labor for assistance and information on an individual's rights under ERISA and HIPAA.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Persons Eligible

As shown in the section entitled "Schedule of Eligibility" found in your Benefit Plan.

Benefits

Health

Loss or Change in Benefits

It is the intent of your Plan Administrator to continue this Plan indefinitely. However, your Plan Administrator retains the right to amend or terminate the Plan at any future

time. No consent of any participant or beneficiary is required to terminate, modify, amend or change the Plan.

Your coverage and your dependents' coverage terminates for fraud or intentional misrepresentation of a material fact by you in connection with an application for coverage or claim for benefits, when you leave employment, when you are no longer eligible, if you fail to make the required contributions, or the Benefit Plan terminates, whichever happens first. In addition, your spouse's coverage terminates at the time of legal separation or the entry of a final decree of divorce or other legal termination of marriage.

Note: If you cease active work, contact your Plan Administrator to determine what arrangements, if any, may be made to continue coverage for you and your dependents beyond the date you cease active work.

Rights and protections

As a participant in the Benefit Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Benefit Plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office or your local personnel office all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. Blue Cross & Blue Shield of Mississippi may make a reasonable charge for the copies.

3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and the other Plan participants and beneficiaries.

No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have Blue Cross & Blue Shield of Mississippi review and reconsider the claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the material and pay you up to $110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond

the control of Blue Cross and Blue Shield of Mississippi. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the Employee Benefits Security Administration, Department of Labor.

Plan benefits insured by

Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company
(A member of the Blue Cross and Blue Shield Association,
an Association of independent Blue Cross and Blue Shield Plans)
3545 Lakeland Drive
Flowood, Mississippi 39232-9799

Schedule of Benefits

Blue Care Group

Benefit Plan Year

A period of one calendar year commencing each January 1 through December 31.

Deductible Amounts

Individual Medical Deductible	**$1,250**
Family Maximum Deductible	**$2,500**
Non-Network Individual Medical Deductible	**$2,500**
Non-Network Family Medical Deductible	**$5,000**
Prescription Drug Deductible Individual	**$100**

The Deductible Amounts listed above are separate and distinct. These Deductible Amounts are not interchangeable. The Network Medical and Prescription Drug Deductibles do not apply where there is a Co-payment amount, except in the case of Category 2, 3, and 4 Prescription Drugs and the Non-Emergency Room Co-payment. If the Member is referred by the Network Provider to another Network or Non-Network Provider for additional services including, but not limited to, laboratory or diagnostic services, the applicable Network or Non-Network Deductible will apply, dependent upon the place of treatment. Network Co-payment amounts do not accrue toward the Network Deductible Amounts but do accrue to the Out-of-Pocket Maximum.

The Member must satisfy the Network Medical Deductible and Prescription Drug Deductible prior to Benefits being paid for Covered Services rendered by a Network Provider.

The Member must satisfy the Non-Network Medical Deductible prior to Benefits being paid for Covered Services rendered by a Non-Network Provider.

Out-of-Pocket Maximum

Network Provider

Individual Out-of-pocket	**$7,000**
Family Out-of-pocket	**$14,000**

When a Subscriber's or Dependent's Out-of-pocket expenses for Deductibles, Co-payments and Co-insurance for Covered Services rendered by Network Providers reach the Out-of-pocket amount during a Calendar Year, Allowable for Covered Services rendered by Network Providers will be paid at 100% (where applicable) for the remainder of the Calendar Year.

The Member's Out-of-pocket expenses for the Non-Network Medical Deductible amount and Co-insurance for Covered Services rendered by Non-Network Providers will not be applied to the Out-of-pocket amount. Allowable for Covered Services rendered by a Non-Network Provider will not be paid at 100% of the Allowable after the Out-of-pocket has been satisfied.

Blue Primary Care Home

Through a Blue Primary Care Home, the Member will establish a relationship with their Blue Primary Care Network Provider who will provide coordinated and continuing care. The Member should designate a Blue Primary Care Network Provider located and practicing in Mississippi who is accepting patients and who will provide their *Healthy You!* visit and Color Me Healthy! Covered Services, if applicable. If the Member does not designate a Blue Primary Care Network Provider, the Company may designate one for the Member. The Blue Primary Care Home extends to our youngest Members, ages 0 through 17 years, with care provided through a Pediatric Blue Primary Care Home.

Members who reside outside of Mississippi should select a Primary Care Home Network Provider located and practicing in their state of residence, where available.

Referral by a Blue Primary Care Network Provider is not needed for obstetrical or gynecological care by a Network Provider specializing in obstetrics or gynecology. However, the obstetrician/gynecologist may be required to comply with certain procedures, including following a pre-approved treatment plan or procedures for making referrals.

For information on how to select a Blue Primary Care Network Provider, and for a list of Blue Primary Care Network Providers, please use the Network Provider search tool located on Company's website at www.bcbsms.com or contact our Customer Service Team at 601-664-4590 or 800-942-0278.

Benefits

The Member must designate a *Healthy You!* or Blue Primary Care Network Provider who is a Network Provider located and practicing in the State of Mississippi and who is accepting patients.

Company will provide Benefits for Covered Services as specified below. Benefits are based on the Allowable minus: (1) any applicable Deductible Amount, (2) any applicable Co-payment, and/or (3) any applicable Co-insurance.

All Covered Services are subject to Care Management. Certain Benefits will only be provided when the Member receives Covered Services from Network Providers that are designated by the Company as a Center of Excellence or as a Network Provider privileged/credentialed and approved by the Company for the Covered Services.

Covered Services	Benefit	
	Blue Primary Care Network Provider or *Healthy You!* Network Provider	**Non-Network Provider**
***Healthy You!* Preventive Health Services**	**100%** (Deductible Waived)	**Not Covered**

Outpatient Services, based on age/sex parameters, must be rendered by a *Healthy You!* Network Provider designated by the Company who is a Network Provider located and practicing in Mississippi and who is accepting patients. Members who reside outside of Mississippi should select a Network Provider located and practicing in their state of residence. Services must be provided in that Provider's clinical setting. See the *Healthy You!* Preventive Health Services Age and Gender Guidelines located on *my*Blue® for the Covered Services.

	Color Me Healthy! Network Provider	**Non-Network Provider**
Color Me Healthy!	**100%**	**Not Covered**

Outpatient Services rendered by a Color Me Healthy! Network Provider designated by the Company when the Member is enrolled in the Color Me Healthy! Benefit that focuses on the treatment and control of metabolic health risks and diseases as defined by the Company.

Members with a Blue Primary Care Home will receive *Healthy You!* and Color Me Healthy! Covered Services from their selected Blue Primary Care Network Provider.

Specialty Services

All Specialty Services are subject to Medical Policy, including Medical Necessity, and a determination by the Company of the most clinically appropriate setting. Specialty Services are only covered at the higher Benefit level stated in the Schedule of Benefits when provided by a Center of Excellence Provider or a Blue Specialty Network Provider. No Benefits will be provided without Pre-Certification or Prior Authorization.

	Blue Specialty Network Provider	Non-Blue Specialty Network Provider	Non-Network Provider
Ambulatory Services	**90%**	**70%**	**Not Covered**

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
Inpatient Services*	**90%**	**70%**	**Not Covered**
Outpatient Services*	**90%**	**70%**	**Not Covered**
Physician Surgeon Services	**90%**	**70%**	**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.

Specialty Services do not include Maternity Services regardless of whether the services are provided by a Network Provider designated as a Center of Excellence.

When a Member receives Specialty Services at a Center of Excellence Network Provider, only the Network facility and the Network Physician surgeon at the Center of Excellence performing the covered Specialty Service will be paid at the higher Co-insurance level. Other Network professional Covered Services to include anesthesia will be paid at the Network Provider Co-insurance level.

SPECIALTY SERVICES - Treatment and care related to the following services:

A. Cardiac Care – including, but not limited to, non-emergent cardiac percutaneous coronary interventions, coronary artery bypass graft surgery, and cardiac valve replacement;

B. Spine Surgery – including, but not limited to, discectomy, spinal fusion, and spinal decompression procedures;

C. Orthopedic Services – including, but not limited to, shoulder, knee and hip replacement; and

D. Other Specialty Services as defined by the Company.

When a Member receives a Specialty Service in a Specialty Service Area with no designated Center of Excellence or Blue Specialty Network Provider, this section will not apply and services will be considered under the Hospital or Physician Services sections set out below.

See a listing of the BCBSMS Centers of Excellence and Blue Specialty Network Providers located on the secure *my*Blue Member portal at www.bcbsms.com.

Hospital Services

(HOSPITAL SERVICES are those services that are not included under Specialty Services.)

All Hospital Admissions (to include Emergency, Mental Health Disorder, and Substance Use Disorder Admissions) are subject to Care Coordination as outlined in Article XIII, Care Management.

Only certain Covered Services will be covered in a Hospital setting, and the Company may require Care Coordination (excluding maternity Benefits) for a determination by the Company of the most clinically appropriate setting.

	Network Provider	Non-Network Provider
Inpatient Hospital Services	**80%**	**50%**
Other Services	**80%**	**50%**
Maternity Benefits (Limited to Benefits described in Article VII)	**80%**	**50%**
Inpatient Rehabilitation Services (Limited to 30 Inpatient days per Calendar Year)	**80%**	**Not Covered**
Outpatient Hospital Services	**80%**	**50%**
Emergency Room Services (Professional Services are included) (Deductible Applies)		
Emergency	**80%**	**80%**
Non-Emergency	**80% after $350 Co-pay**	**50% after $350 Co-pay**

When the Member obtains Emergency Room Services from a Network Provider (Hospital) or Non-Network Provider (Hospital) in the case of Mental Health Disorders or Substance Use Disorders, Covered Services will be subject to the Medical Emergency Benefit. Network Benefits will be applied subject to the Member satisfying the Benefit Period Deductible Amount.

	Network Provider	Non-Network Provider
Ambulatory Surgical Facility Services (ASF)	**80%**	**50%**

	Network Provider		Non-Network Provider
Physician Services (M.D. and D.O. only)	**Primary Care**	**Specialist**	
Office Visits (The Co-pay does not apply to any Other Services rendered in the Physician's Office.)	**$25 Co-pay** (Family Practice, General Practice, Internal Medicine, Pediatricians, and OB/GYN)	**$40 Co-pay**	**50%**
Other Office Services rendered in the Physician's Office (The term "Services" does not include Durable Medical Equipment, Prosthetics or Orthotic Devices.) (Deductible does not apply to services rendered in a Network Physician's Office.)	**80%**		**50%**
Other Physician Services	**80%**		**50%**

	Network Provider	Non-Network Provider
Newborn Well Baby Care (Subsequent visits, circumcision and discharge of baby)	**80%**	**50%**

Other Covered Services	Benefit	
	Network Provider	**Non-Network Provider**
Allied Primary Care Health Professional		
Office Visits (The Co-pay does not apply to any Other Services rendered in the office.)	**$25 Co-pay**	**50%**
Other Services rendered in the Office (Deductible does not apply to services rendered in a Network Provider's office.)	**80%**	**50%**

	Network Provider	**Non-Network Provider**
Allied Specialist		
Office Visits (The Co-pay does not apply to any Other Services rendered in the office.)	**$40 Co-pay**	**50%**
Other Services rendered in the Office (Deductible does not apply to services rendered in a Network Provider's office or facility.)	**80%**	**50%**
Other Allied Primary Care and Specialist Provider Services	**80%**	**50%**

When Physical Medicine Services are provided, Benefits will be limited to 20 visits per Calendar Year, subject to Medical Necessity, and three (3) modalities per visit. Visit limits apply to Physical Medicine visits in the home and at the Allied Specialist's office or facility. No Benefits will be provided for services provided by Non-Network Physical Therapists, Occupational Therapists, or Chiropractors. In addition, no Benefits will be provided for Physical Medicine services provided by a Non-Network Provider.

Ambulance Services	**80%**	**50%**
Allergy Injections/Testing Services	**80%**	**50%**
Diagnostic Services Facility	**80%**	**Not Covered**
Dialysis Treatment	**80%**	**Not Covered**
Durable Medical Equipment (Medical Necessity Certificate Required)	**80%**	**Not Covered**

	Network Provider	Non-Network Provider
Habilitative Care Physical Therapy and Occupational Therapy (Limited to 20 visits, combined, per Calendar year)	80%	Not Covered
Speech Therapy (Limited to 20 visits per Calendar Year)	80%	50%
Hospice Care (Limited to 6 months per the lifetime of the Member) (Subject to Care Management)	80%	Not Covered
Independent Laboratory	80%	Not Covered
Infusion Therapy (Subject to Care Management)	80%	Not Covered
Orthotic Devices (Medical Necessity Certificate Required)	80%	80%
Outpatient Cardiac Rehabilitation (Covered Services must be rendered by a Network Provider that is a Certified Facility) (Visit limits are based on the severity of patient's condition, not to exceed 36 visits)	80%	Not Covered
Physical Medicine (Limited to 20 visits per Calendar Year) (Limited to 3 Modalities per visit)	80%	Not Covered
Prosthetic Appliances (Medical Necessity Certificate Required)	80%	80%
Sleep Studies (Services must be rendered by a facility or home sleep study Network Provider accredited by AASM)	80%	Not Covered
Speech Therapy (Limited to 20 Rehabilitative Care visits per Calendar Year)	80%	50%
Therapy Services	80%	Not Covered

Prescription Drugs

No Benefits will be provided for any Prescription Drug not included in Company's Prescription Drug Formulary or Maintenance Drug Formulary. All Prescription Drug Benefits are subject to Care Management to include Prior Authorization which may be required prior to Benefits being provided, Medical Necessity and appropriateness of care.

Only those Prescription Drugs within the Maintenance Drug Formulary are eligible for a 90-day supply.

If a generic equivalent Prescription Drug, Interchangeable Biological Product or Biosimilar Product is available, but the member purchases the brand name or Reference Biologic Medication, the Member will be responsible for the entire cost of the drug. Benefits for Prescription Drugs are subject to Quantity Limits and/or day limits and Medical Policy. No Benefits will be provided for Prescription Drugs prescribed or dispensed beyond the Quantity Limits and/or day limits. Certain Prescription Drugs are subject to clinically appropriate duration of use restrictions based upon the usual course of treatment. Benefits may be reduced if the Member uses a drug manufacturer's coupon which reduces or eliminates the Member's liability.

As part of Generic First, certain Prescription Drugs that have a generic, Interchangeable Biological Product, Biosimilar Product or lower cost alternative may be subject to a trial usage of the generic alternative drug, Interchangeable Biological Product or Biosimilar Product 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 Four 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.

The Prescription Drug Deductible (if applicable) only applies to those drugs that are in Categories Two, Three or Four.

	Community PLUS Pharmacy	Non-Community PLUS Pharmacy
Prescription Drugs (Limited to a 30-day supply)		
Category One Drugs	**100% after $10 Co-pay**	**Not Covered**
Category Two Drugs	**100% after $25 Co-pay**	**Not Covered**
Category Three Drugs	**100% after $50 Co-pay**	**Not Covered**
Category Four Drugs	**100% after $100 Co-pay**	**Not Covered**

Maintenance Drugs (A 90-day supply)	Community PLUS Maintenance Pharmacy Generic	Community PLUS Maintenance Pharmacy Brand	Non-Maintenance Pharmacy
Category One Drugs	**100% after $25.00 Co-pay**	**100% after $30 Co-pay**	**Not Covered**
Category Two Drugs	**100% after $62.50 Co-pay**	**100% after $75 Co-pay**	**Not Covered**
Category Three Drugs	**100% after $125.00 Co-pay**	**100% after $150 Co-pay**	**Not Covered**
Category Four Drugs	**100% after $250.00 Co-pay**	**100% after $300 Co-pay**	**Not Covered**

	Network Provider	Non-Network Provider
Disease Specific Drugs (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 $350 Co-pay with a minimum $100 Co-pay.**	**Not Covered**

No Benefits will be provided for any Disease Specific Drug not included in Company's Disease Specific Drug Formulary. Benefits will not be provided if the Member receives financial assistance from a drug manufacturer or if the Member has no obligation to pay for the Disease Specific Drug.

	Network Provider	Non-Network Provider
Medical Prescription Drugs (Drugs must be dispensed or administered by a Hospital, Physician or Allied Provider and Listed in the Medical Prescription Drug Formulary. Medical Deductible Applies.)	**80%**	**50% or Not Covered***

* Non-Network Provider Benefits may vary by place of treatment. No benefits will be provided if the Non-Network Provider's services are not covered as outlined in the Schedule of Benefits. Benefits will not be provided if the Member receives financial assistance from a drug manufacturer or if the Member has no obligation to pay for the Medical Prescription Drug.

Mental Health and Substance Use Disorder Benefits

All services are subject to Care Management, Medical Necessity and appropriateness of care.

	Network Provider	Non-Network Provider
Inpatient Care	**80%**	**50%**
Inpatient Rehabilitation Services	**80%**	**50%**
Residential Treatment Center	**80%**	**50%**
Partial Hospitalization	**80%**	**50%**
Outpatient Hospital Visits	**80%**	**50%**
Other Outpatient Physician and Allied Provider Services	**80%**	**50%**
Physician and Allied Provider Office Visits (Co-pay does not apply to any Other Services rendered in the Physician or Allied Provider's Office)	**$25 Co-pay**	**50%**
Other Services rendered in the Physician and Allied Provider's Office (Deductible does not apply to services rendered in a Network Physician or Allied Provider's Office.)	**80%**	**50%**

Organ and Tissue Transplant Benefits

In order for the Member to receive Network Benefits for Covered Services for a transplant procedure, all of the following provisions must be satisfied: (1) The Member must receive Covered Services from a Network Provider approved and designated by the Company for the particular transplant surgery and (2) The Member's Network Provider must receive Prior Authorization from the Company. Services provided by a Non-Network Provider are Non-covered Services.

	Network Provider	Non-Network Provider
Renal Transplants	**80%**	**Not Covered**
Other Solid Organ Transplants (Liver, Heart, Lung)	**80%**	**Not Covered**
Tissue Transplants (Bone Marrow Transplants)	**80%**	**Not Covered**
Donor Benefits	**100%**	**Not Covered**

Temporomandibular/Craniomandibular Joint Disorder (TMJ)

Prior Authorization is required. No Benefits will be provided unless Network Provider receives Prior Authorization from Company.

	Network Provider	Non-Network Provider
Surgery/Diagnostic Services and removable oral appliances for TMJ	**80%**	**Not Covered**

Diabetes Treatment

	Network Provider	Non-Network Provider
Equipment, Supplies for the monitoring of blood glucose and insulin administration. (Home glucose monitors limited to 1 monitor every 2 years)	**80%**	**Not Covered**
Diabetes Self-Management Training (Limited to six (6) hours per Calendar Year)	**80%**	**Not Covered**
Dilated Eye Exam (Limited to one exam per Calendar Year)	**80%**	**Not Covered**
Preventive Routine Foot Care (Limited to one visit per Calendar Year)	**80%**	**Not Covered**

	Network Provider	Non-Network Provider
Other Preventive Health Services (Outpatient) (Based on Age/Sex Parameters)	**100%** (Deductible Waived)	**Not Covered**

Services must be rendered by a Network Provider approved by Company in that Provider's clinical setting. Covered Services must be included in the Grade A and B Recommendations of the United States Preventative Services Task Force. Covered Services also include all other preventive health services required by the Patient Protection and Affordable Care Act.

	Network Provider	Non-Network Provider
Pediatric Vision Services (Available only for Members under the age of 19) (Deductible does not apply)		
Routine Eye Exam	**$40 Co-pay**	**Not Covered**
Eyeglasses (One Pair per year, subject to limitations contained in this Benefit Plan)	**100% up to $150**	**Not Covered**

	Network Provider	Non-Network Provider
Pediatric Dental Services (Available only for Members under the age of 19) (Deductible does not apply)		
Preventive Dental Services (Preventive and Diagnostic Services)	**80%**	**80%**
Other Dental Services (As defined in this Benefit Plan)	**50%**	**50%**

Article I

Definitions

Many of the definitions contained in Article I describe different types of services or supplies which may or may not be Covered Services under this Benefit Plan. For full details of Covered Services and Non-covered Services, please refer to the Benefit sections and the Limitation and Exclusion section.

Accidental Injury - A condition occurring as a direct result of a traumatic bodily injury sustained solely through accidental means from an external force. With respect to injuries to teeth, the act of chewing does not constitute an injury caused by external force.

Acute Care - Inpatient care provided for an illness, injury or condition, which is Medically Necessary to reach a point of stability that would allow a patient to: (1) receive care on an outpatient basis, (2) receive home care, or (3) transfer to a facility for further treatment including any Rehabilitative Care facility.

Admission - The period from entry (Admission) into a Hospital for Inpatient care, until discharge. In counting days of care, the date of entry and the date of discharge are counted as one day.

Allied Health Facility - An institution, other than a Hospital, licensed by the appropriate state agency where required, and/or approved by Company to render Covered Services.

Allied Health Professional - A person other than a Medical Doctor, or Doctor of Osteopathy who is certified and/or licensed by the appropriate state agency, where required and/or approved by Company to render Covered Services. An Allied Health Professional includes the following provider types: dentists, psychologists, licensed certified social workers, certified nurse practitioners, physician assistants, optometrists, chiropractors, podiatrists, physical therapists, speech pathologists, audiologists, and certified registered nurse anesthetists. Services rendered by other health professionals are not covered unless mandated by state law for specified services or otherwise stated within this Benefit Plan. For purposes of this Benefit Plan, Allied Health Professionals are divided into two types:

A. **Allied Primary Care Health Professionals -** A person who is licensed by the appropriate state agency and approved by Company to render Covered Services to a Member, which are within the lawful scope of his or her license. For purposes of this Benefit Plan, Certified Nurse Practitioners, Certified Nurse Mid-wives and Physician Assistants will be designated as Allied Primary Care Health Professionals.

B. **Allied Specialist -** An Allied Health Professional, other than a Certified Nurse Practitioner, who is certified and/or licensed by the appropriate state agency and approved by Company to render Covered Services to a Member, which are within the lawful scope of his or her license. For the purposes of this Benefit Plan, Allied Health Professionals, other than Certified Nurse Practitioners, Certified Nurse Mid-wives and Physician Assistants, will be designated as Allied Specialist.

Allied Provider - Any Allied Health Facility or Allied Health Professional.

Allowable - The lesser of the: (1) Covered Charges or (2) the amount established by Company as the maximum amount for Provider services covered under the terms of this Benefit Plan. The Allowable for Network Providers and Non-Network Providers may vary. For the purposes of the BlueCard Program, the Allowable may be determined by the out-of-state Blue Cross and Blue Shield Plan (See Article XV, for Out-Of-Area Services).

Ambulance Service - Medically Necessary transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured.

Ambulatory Services - Covered Services which, pursuant to Medical Policy, including Medical Necessity, are clinically appropriate to be performed in a non-Hospital setting and are performed in a facility approved and designated as such by the Company.

Ambulatory Surgical Facility - A distinct entity approved by the Company that operates exclusively for the purpose of providing surgical services to patients not requiring inpatient hospitalization and in which the expected duration of services would not exceed 24 hours following an admission. An Ambulatory Surgical Facility is not a facility used as an office or clinic, other than incidentally, for the private practice of a physician.

Applied Behavior Analysis - The design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Assistant at Surgery - A Physician, Physician Assistant, Certified Nurse Practitioner or Certified Registered Nurse First Assistants who assists the primary surgeon in the performance of a covered surgical procedure.

Autism Spectrum Disorders - A physical, mental, or cognitive illness or disorder which includes any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders ("DSM") published by the American Psychiatric Association, including Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified.

Benefit - The amount provided under this Benefit Plan for Covered Services. Benefits are based on the Allowable minus any applicable Deductible Amount, Co-payment or Co-insurance.

Benefit Plan - This agreement, including the Employer Application, Group Application (where applicable), Company Acceptance (where applicable), Subscriber Application, and riders, if any, entitling the Subscriber and covered Dependents to specified healthcare coverage.

Benefit Plan Year - A period of one calendar year commencing each January 1 through December 31. Benefit Plan Year may not be the same as a Member’s Effective Date or renewal date.

Benefit Period - A period of one calendar year commencing each January 1 through December 31.

Billed Charges - The total charges submitted by a Provider for all Covered Services and Non-covered Services provided to a Member.

Biological Product - A virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergic product, protein, or analogous product, or arsphenamine or derivative of arsphenamine (or any other trivalent organic arsenic compound), applicable to the prevention, treatment, or cure of a disease or condition of human beings.

Biosimilar Product – A Biological Product that is highly similar to and has no clinically meaningful differences from an existing FDA-approved Reference Biologic Medication. A Biosimilar Product may not be substituted for the Reference Biologic Medication without the involvement of the prescriber.

Blue Primary Care Home – A relationship between Member and their Blue Primary Care Network Provider focused on achieving quality health outcomes based upon an individualized health and wellness plan. Member's wellness plan is coordinated by the Blue Primary Care Network Physician and their health team who are committed to improving Member's overall health and achieving Member's health goals. A Certified Nurse Practitioner, if approved and designated by the Company, may provide certain Covered Services as a Blue Primary Care Network Provider, as part of the Blue Primary Care Home. The Certified Nurse Practitioner must practice under the supervision of a Blue Primary Care Network Physician on the Blue Primary Care Network Physician's premises.

Blue Primary Care Network Physician – A Physician who is a Network Provider for the purposes of this Benefit Plan, is approved by the Company, and who provides wellness, metabolic management and care coordination for its attributed Members as part of the Blue Primary Care Home.

Blue Primary Care Network Provider - A Blue Primary Care Network Physician or Certified Nurse Practitioner who is a Network Provider for the purposes of this Benefit Plan, is approved and designated by the Company, and who provides wellness, metabolic management and care coordination for its attributed Members as part of the Blue Primary Care Home.

Blue Specialty Network Provider - A Network Provider that provides Specialty Services. The Blue Specialty Network Provider designation is made by the Company subject to the execution of a value-based agreement which establishes best practices and quality outcomes for the Specialty Services.

Care Management - The identification of members with health risks and assisting members in collaboration with a Blue Primary Care Network Provider or Network Provider with improving their health status through programs that are designed to facilitate appropriate, quality and cost-effective medically necessary care and the management of certain disease states. Care Management includes but is not limited to the following: 1) Utilization Management, 2) Case Management, 3) Disease Management, and 4) Prescription Drug Utilization Management.

Case Management - The coordination of a comprehensive plan of action for Members with complex healthcare needs. Case managers collaborate with Members, their families, and Network Providers to promote care in the most cost effective setting, and facilitate efficient, appropriate and cost effective care. The goal of Case Management is to provide effective, appropriate and quality management of high risk, high cost and/or

catastrophic cases. In administering Case Management, Company will utilize the benefits specified in this Benefit Plan.

Category One Drugs - This category of drugs generally includes low-cost generic and some brand-name drugs.

Category Two Drugs - This category of drugs generally includes higher-cost generic and many brand-name drugs.

Category Three Drugs - This category of drugs generally includes some brand-name drugs, and some generic drugs. These drugs may have generic or brand-name alternatives in Category One or Two.

Category Four Drugs - This category of drugs generally includes high cost generic drugs, high cost technology drugs and specialty drugs.

Center of Excellence - A Network Provider that specializes in certain illnesses and/or treatments. Center of Excellence designation is based on criteria established by the Company.

Certified Diabetes Educator - A Diabetes Educator who currently holds a certification from the National Certification Board for Diabetes Educators.

Clinical Trial - Means an approved clinical trial as defined by the Patient Protection and Affordable Care Act.

COBRA - The Consolidated Omnibus Budget Reconciliation Act of 1985, commonly referred to as COBRA, requires that employers allow certain persons deemed "Qualified Beneficiaries," who would otherwise lose their group health coverage due to certain "Qualifying Events" to continue that coverage for a certain period of time (See General Provisions Section).

Co-insurance - That portion of the Allowable expressed as a percentage for which the Member is financially responsible under this Benefit Plan.

Color Me Healthy! - A Disease Management Benefit that focuses on the treatment and control of metabolic health risks and diseases as defined by the Company.

Color Me Healthy! Network Provider – A Blue Primary Care Network Provider or Color Me Healthy! Specialist, who is approved and designated by the Company, committed to wellness and metabolic best practices, and who agrees to provide and to be reimbursed for Color Me Healthy! Covered Services pursuant to a Color Me Healthy! agreement.

Color Me Healthy! Specialist – A Physician or Certified Nurse Practitioner who is a Network Provider, who is approved and designated by the Company, committed to wellness and metabolic best practices, and who agrees to provide and to be reimbursed for Color Me Healthy! Covered Services pursuant to a Color Me Healthy! agreement.

Community PLUS Maintenance Pharmacy - A Community PLUS Pharmacy that has entered into an agreement with Company to dispense a 90-day supply of Maintenance Drugs.

Community PLUS Pharmacy - A pharmacy which has entered into an agreement with Company (and has met the criteria for the Community PLUS Network) wherein the

Community PLUS Pharmacy agrees to render pharmaceutical services to Members of this Benefit Plan. A Community PLUS Pharmacy is also referred to as a Network Pharmacy.

Company - Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company.

Concurrent Care - Hospital Inpatient medical and surgical care by a Physician, other than the attending Physician; (1) for a condition not related to the primary diagnosis or, (2) because the medical complexity of the patient's condition requires additional medical care.

Consultation - Another Physician's opinion or advice as to the evaluation or treatment of a Member which is furnished upon the request of the attending Physician. These services are not intended to include those Consultations required by Hospital rules and regulations, anesthesia Consultations, routine Consultations for clearance for Surgery, or Consultations between colleagues who exchange medical opinions as a matter of courtesy and normally without charge.

Continued Stay Review - A review to determine the Medical Necessity of continued hospitalization beyond the initial approved length of stay and level of care.

Co-payment - That portion of the Allowable expressed as an amount for which the Member is financially responsible under this Benefit Plan.

Cosmetic Services – Any non-operative procedure or laser service designed to restore, change or enhance physical appearance.

Cosmetic Surgery - Any operative procedure or any portion of an operative procedure intended solely to improve physical appearance. Exceptions to the above procedures are those procedures which restore bodily function or correct deformity resulting from disease, trauma or complications of previous Surgery. (See Article XIV, Limitations and Exclusions.)

Covered Charges - Provider Charges for Covered Services. Covered Charges are Billed Charges minus Non-covered Charges.

Covered Service - A service or supply specified in this 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 Amounts

A. **Network Medical Deductible -** The dollar amount, as shown in the Schedule of Benefits, for Covered Services that the Member must incur before Benefits are available under this Benefit Plan for covered services and supplies provided by a Network Provider.

B. **Prescription Drug Deductible -** The dollar amount, as shown in the Schedule of Benefits, for covered Prescription Drugs that the Member must incur before Benefits are available under this Benefit Plan for covered Prescription Drugs.

C. **Non-Network Medical Deductible Amount**

1. "Non-Network Medical Deductible Amount" - The dollar amount, as shown in the Schedule of Benefits, for Covered Services that the Member must incur before Benefits are available under this Benefit Plan for covered services and supplies provided by a Non-Network Provider.

2. The "Non-Network Medical Deductible Amount" cannot be used toward satisfying the "Network Medical Deductible Amount."

Dental Care and Treatment - All procedures, treatment, and Surgery considered to be within the scope of the practice of dentistry, which is defined as follows:

> The diagnosis or profession to diagnose, or the examination or contracting for the treatment of, or treating or professing to treat, or holding oneself out as treating any of the diseases or disorders or lesions of the oral cavity, teeth, gingivae, or maxillary bones, the extraction of teeth, repair or filling of cavities in human teeth, the correction of malposition or irregularities of the teeth or jaws, the practice of Surgery of the head or neck incident to the practice of Oral Surgery, or the construction, repair or mending of artificial teeth, crowns, or bridges. The administration of anesthetics or the use of X-rays in connection with any of the above-referenced acts is defined as the practice of dentistry as is any other practice which is included in the curricula of dental schools accredited by the Council on Dental Education or the American Dental Association.

Dental Implants - Devices specially designed to be placed surgically within the mandibular or maxillary bone as a means of providing for dental replacement.

Dependent - A person, other than the Subscriber, who has been accepted for coverage as specified in and determined by the Schedule of Eligibility.

Diabetes - Diabetes mellitus is a disorder of carbohydrate metabolism, characterized by hyperglycemia and glycosuria and resulting from inadequate production or utilization of insulin.

Diabetes Self-Management Training - Diabetes Self-Management Training is the teaching and the learning of the body of knowledge, attitudes, and self-management skills related to the control of Diabetes. The ultimate goal of training is to promote the behavior changes necessary for optimal health outcomes, psychosocial adaptation, and quality of life.

Diagnostic Service - Radiology, laboratory, and pathology services and other tests or procedures recognized by Company as accepted medical practice, rendered because of specific symptoms, and which are directed toward detection or monitoring of a definite condition, illness or injury. A diagnostic service performed by a Network Diagnostic Service Facility must be ordered by a licensed Network Provider and provided by a licensed Network Provider.

Diagnostic Service Facility - A facility which performs Diagnostic Services.

Dialysis Treatment - The treatment of an acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body ordinarily removed by the kidneys, to include hemoperfusion, hemodialysis or peritoneal dialysis.

Disease Management - Coordinated healthcare interventions and communications for Members with conditions in which patient self-care efforts are significant. Disease Management supports the Network Provider/Member relationship and plan of care, emphasizes prevention and utilizes evidence-based practice guidelines.

Disease Specific Drugs - Prescription Drugs that (a) are used to treat complex and chronic conditions; (b) may require special administration; (c) may require monitoring, patient education and/or clinical support; (d) need frequent or careful dosage adjustments; (e) have unusually high costs; or (f) as otherwise defined by Company.

Disease Specific Drug Formulary - A list of Disease Specific Drugs which have been reviewed by a committee of Network physicians and pharmacists as well as approved by Company.

Disease Specific Pharmacy - A Provider that has an area of expertise in disease states as well as the drugs used to treat disease states. In order to be considered a Disease Specific Pharmacy under this Benefit Plan, Company must have a Disease Specific Pharmacy Arrangement with the Provider.

Durable Medical Equipment - Items which are used to serve a medical purpose, can withstand repeated use, are generally not useful to a person in the absence of illness, injury, or disease, and are appropriate for use in the patient's home. Construction costs to the Member's residence to accompany the equipment are not considered Durable Medical Equipment.

Effective Date - The date when the Member's coverage begins under this Benefit Plan as determined by the Schedule of Eligibility.

Elective Admission - Any Inpatient Hospital Admission, whether it be for surgical or medical care, for which a reasonable delay will not unfavorably affect the outcome of the treatment.

Election Notice - For purposes of COBRA only, a document specifying details for a Qualified Beneficiary of the opportunity to continue health plan coverage (See General Provisions Section).

Eligible Person - A person entitled to apply to be a Subscriber as specified in the Schedule of Eligibility.

Emergency - See "Medical Emergency."

Emergency Admission - "Emergency Admission" may be an "Emergency Medical Admission" or "Emergency Psychiatric Admission."

A. "Emergency Medical Admission" means an Inpatient Admission to a Hospital resulting from the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate Inpatient Hospital care could reasonably result in:

    1. Permanently placing the patient's health in jeopardy;

    2. Serious impairment to bodily functions; or

    3. Serious and permanent dysfunction of any bodily organ or part, or other serious medical consequences.

B. "Emergency Psychiatric Admission" means an Inpatient Admission to a Hospital resulting from a mental illness or substance use disorder with presenting symptoms of such severity that, in the absence of immediate intervention, could reasonably result in:

1. Permanently placing the patient's mental health in jeopardy;

2. A serious threat to the physical welfare of the patient and/or others; or

3. Serious or permanent mental dysfunctions or other medical or psychiatric consequences. The acute symptoms must be of such severity as to cause a prudent layperson to seek medical or psychiatric assistance regardless of the hour of the day or night.

Gene Manipulation Therapy – is a form of Gene Therapy which involves altering an individual's DNA to treat or prevent disease, or potentially enhance traits using biotechnology.

Generic First - A Prescription Drug that requires the use of a generic drug and clinical justification before benefits will be available for a brand name drug (See Article VIII, Prescription Drug Benefits).

Good Health Club – A program that focuses on Member's overall healthcare and wellness experience in the Pediatric Blue Primary Care Home, to include a preventive healthcare, wellness education, and health management.

Habilitative Care - The coordinated use of medical, social, educational or vocational services, necessary to address a disabling health condition, to assist a Member in acquiring or improving skills and functioning necessary for daily living that the Member never acquired or possessed due to the disabling health condition. Services may include physical therapy, occupational therapy, and speech therapy. A disabling condition is a physical or mental impairment (or combination of impairments) due to disease, trauma, congenital anomalies or prior therapeutic intervention that causes marked and severe function limitations and has lasted or is expected to last at least one year. Dysfunctions that are self-correcting, such as natural dysfluency or developmental articulation errors that are self-correcting are not disabling conditions.

***Healthy You!* Network Provider -** A Primary Care Network Physician or Certified Nurse Practitioner who is approved and designated by the Company, and who is located and practicing in the State of Mississippi. Members who reside outside of Mississippi should select a Network Provider located and practicing in their state of residence. Primary Care Network Physicians include: family practice, general practice, internal medicine, pediatrics and obstetrics/gynecology. Certain *Healthy You!* Covered Services may be provided by a Network Specialist or Network Hospital approved by the Company.

Home Health - Health services rendered in the individual's place of residence by an organization that is licensed as a home health Provider by the appropriate state agency, is a Network Provider, and/or is approved by Company. These organizations are primarily engaged in providing to individuals, at the written direction of a licensed Physician, in the individual's place of residence, skilled nursing services by or under the supervision of a Registered Nurse licensed to practice in the state in which services are rendered and/or social work service provided by a medical Social Worker licensed and certified to practice in the state in which services are rendered.

Hospice Care - Provision of an integrated set of services and supplies designed to provide palliative and supportive care to meet the special needs of Members and their families during the final stages of terminal illness, normally six months or less. Full scope health services are centrally coordinated through an interdisciplinary team directed by a Physician and provided by a Network Provider through a Hospice Care agency licensed by the state and approved by Company.

Hospital - a short-term, acute-care, general hospital which:

A. is a licensed institution;

B. provides inpatient services and is compensated by or on behalf of its patients;

C. provides surgical and medical facilities primarily to diagnose, treat, and care for the injured and sick; except that a psychiatric hospital will not be required to have surgical facilities;

D. has a staff of physicians licensed to practice medicine; and

E. provides 24-hour nursing care by registered nurses.

Although a Facility may be designated as a Hospital through their state license, Company will determine whether the facility is a Hospital for purposes of Benefits under this Benefit Plan. This determination will be based on the services that the facility provides to the Member. Nursing homes, custodial care homes, rest homes, rehabilitative facilities, Residential Treatment Facilities or places for the aged are not considered Hospitals.

Independent Laboratory - A freestanding laboratory certified to perform diagnostic and/or clinical tests independent of a Hospital or a physician's office.

Infusion Therapy - Services and Supplies required for the administration of an Infusion Therapy regimen. These services and supplies must be (1) Medically Necessary for the treatment of the disease; (2) ordered by a Network Physician; (3) as determined by Company, capable of safe administration; (4) provided by a Network Infusion Therapy Provider approved by Company when Prior Authorization has been obtained from Company; (5) ordinarily in lieu of Inpatient Hospital Therapy; and (6) more cost effective than Inpatient Therapy.

Inpatient - A Member who is a registered bed patient for whom a Bed, Board and General Nursing Service charge is made.

Inpatient Rehabilitation Services - An extensive, inter-disciplinary and multi-disciplinary team approach (e.g., physiatrist, psychiatrists, licensed counselors, therapists, licensed certified social worker, specialized providers in the field of rehabilitation) to the delivery of intensive rehabilitative care. These services must have Care Management approval as well as comply with the Company's criteria for Inpatient Rehabilitation Care. (See Article IV, Hospital Benefits Section and Article IX, Mental Health and Substance Use Disorder Benefits Section).

Inpatient Rehabilitation Facility - A facility providing Inpatient Rehabilitation Services must be accredited by The Joint Commission or DNV Healthcare, Inc. and the Commission on Accreditation of Rehabilitation Facilities (CARF). A facility providing

mental health and/or substance use Inpatient Rehabilitation Services which is not a unit of an acute care Hospital must be accredited by The Joint Commission or CARF. Licensure must be consistent with services provided.

Intensive Outpatient Services - A structured, short-term treatment modality that provides a combination of individual, group and family therapy services. Intensive outpatient programs meet at least three times per week, providing a minimum of three hours of treatment per session. Intensive outpatient programs for mental health and/or substance use disorders must be supervised by a licensed mental health professional. Intensive outpatient treatment is an alternative to inpatient or partial hospital care and offers intensive, coordinated, multidisciplinary services for Members with an active physical functional limitation or psychiatric or substance related illness who are able to function in the community at a minimally appropriate level and present no imminent potential for harm to themselves or others. These services must have Care Management approval and comply with Medical Policy established by the Company.

Interchangeable Biologic Product – A Biosimilar Product that has been licensed by the FDA, is therapeutically equivalent to the Reference Biologic Medication and meets additional requirements outlined by the Biologics Price Competition and Innovation Act. An Interchangeable Biologic Product may be substituted for the Reference Biologic Medication without the involvement of the prescriber.

Investigative - The use of any treatment procedure, facility, equipment, drug, device, or supply not yet recognized as a generally accepted standard of good medical practice for the treatment of the condition being treated and; therefore, not considered Medically Necessary. For the definition of Investigative, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, and physician specialty society recommendations, and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors. In order for equipment, devices, drugs or supplies (i.e., technologies), to be considered not investigative, the technology must have final approval from the appropriate governmental bodies (Food and Drug Administration humanitarian, marketing or similar exceptions, for example, where the effectiveness of the device for the specific indication has not been demonstrated does not constitute final approval), and scientific evidence must permit conclusions concerning the effect of the technology on health outcomes, and the technology must improve the net health outcome, and the technology must be as beneficial as any established alternative and the improvement must be attainable outside the testing/investigational setting.

Low Dose Mammography - The x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, screens, films and cassettes with a radiation exposure (radiation exposure must be in keeping with the recommended Average Patient Exposure Guides As Published By The Conference Of Radiation Control Program Directors, Inc.).

Maintenance Drugs - A Prescription Drug which is; (1) prescribed for a chronic condition, (2) taken on a regular recurring basis, (3) not subject to regular dosage changes; (4) clinically appropriate to be taken on a routine basis; (5) designated by Company to be a Maintenance Drug; and (6) included in Company's Maintenance Drug Formulary.

Maintenance Drug Formulary - A list of Maintenance Drugs approved by the Company that are available at a 90-day supply.

Medical Emergency - The sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could reasonably result in: (1) permanently placing the patient's health in jeopardy; (2) serious impairment of bodily functions; or (3) serious and permanent dysfunction of any bodily organ or part, or other serious medical consequences. Some examples of Medical Emergency are severe chest pain, convulsions, excessive bleeding and a decreased level of consciousness. Conditions that would not warrant emergency care include, but are not limited to, the following conditions: colds, sore throat or flu, arthritis that is recurrent, chronic less severe pain such as earache, headache, sore "pulled muscles" or indigestion, small bruises or scrapes of the skin.

Medical Food – As defined in Section 5(b) of the Orphan Drug Act (21 U.S.C. 360ee(b)(3)) is “a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation.” In general, to be considered a medical food, a product must, at a minimum, meet the following criteria: the product must be a food for oral or tube feeding; the product must be labeled for the dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements; and the product must be intended to be used under medical supervision.

Medical Policy - Company develops formal written guidelines regarding new and existing medical and surgical procedures, products, drugs, technology and tests. These guidelines are determined by review of currently available peer reviewed scientific literature as well as input from practicing professionals. Company relies on Medical Policy for reaching decisions on matters of: 1) Medical Necessity, 2) Covered Services under this Benefit Plan, 3) appropriate adjudication of claims, 4) Care Management, and 5) quality assessment programs. The specific guidelines found in the Medical Policy are not set out in their entirety in this Benefit Plan.

Medical Prescription Drugs – Prescription Drugs dispensed or administered by a Hospital, Physician, Allied Provider or in other healthcare/clinical settings rather than by a Community PLUS Pharmacy, Community PLUS Maintenance Pharmacy, Network Disease Specific Pharmacy or other retail pharmacy.

Medical Prescription Drug Formulary – A list of Drugs covered by Company when administered and billed through the medical setting. The Medical Prescription Drug Formulary provides medical policy, coverage and clinical comparator information to providers servicing the Company’s Members, and may generate savings from drug manufacturers which are used in the financing of this Benefit Plan.

Medically Necessary (or "Medical Necessity") - means those services, treatments, procedures, equipment, drugs, devices, items or supplies furnished by a covered Provider that are required to identify or treat a Member's illness, injury or Mental Health Disorders, and which Company determines are covered under this Benefit Plan based on the criteria as follows in A through D;

A. consistent with the symptoms or diagnosis and treatment of the Member's condition, illness, or injury; and

B. appropriate with regard to standards of good medical practice; and

C. not solely for the convenience of the Member, his or her Provider; and

D. the most appropriate supply or level of care which can safely be provided to Member. When applied to the care of an Inpatient, it further means that services for the Member's medical symptoms or conditions require that the services cannot be safely provided to the Member as an Outpatient.

Company makes no payment for services, treatments, procedures, equipment, drugs, devices, items or supplies which are not documented to be Medically Necessary. The fact that a Physician or other Provider has prescribed, ordered, recommended, or approved a service or supply does not in itself, make it Medically Necessary.

Member - A Subscriber or an enrolled Dependent.

Mental Health Disorder - A condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a Mental Health Disorder and which is not otherwise excluded from coverage under this Benefit Plan.

Modality - Any physical agent applied to produce therapeutic changes to biologic tissue, including but not limited to thermal, acoustic, light, mechanical, or electric energy.

Network Service Area - the County that a Network Provider services as defined by the Company.

Non-covered Charges - Provider charges for Non-covered Services.

Non-covered Services - Healthcare or other services and supplies provided to a Member for which Benefits are not available under this Benefit Plan.

Orthotic Device - A rigid or semi-rigid supportive device which restricts or eliminates motion of a weak or diseased body part.

Out-of-pocket - Unreimbursable expenses incurred by a Member for Covered Services in one Benefit Period. This amount does not include: (a) any charges in excess of the Allowable; (b) any charges incurred by the Member for non-approved days in a Hospital as a bed patient except as provided by law; (c) Non-Network Deductible and Co-insurance Amounts; (d) Benefits paid by Company for Covered Services as specified in this Benefit Plan; or (e) expenses for non-covered services.

Outpatient - A Member who receives services or supplies while not an Inpatient.

Outpatient Cardiac Rehabilitation - The process by which a person with Cardiovascular Disease is restored to their optimal function states, including their physiological, psychological, social, vocational, and emotional states. Cardiac Rehabilitation services include formal exercise sessions, risk factor education, and behavior modification counseling. Member must receive Care Management approval from the Company for Covered Services.

Outpatient Pulmonary Rehabilitation - The multidisciplinary process by which a person with Pulmonary Disease is restored to their optimal function states, including their physiological, social, vocational, and emotional states. Pulmonary Rehabilitation services include team assessment, formal exercise sessions, risk factor education, and

follow-up. Member must receive Care Management approval from the Company for Covered Services.

Outpatient Rehabilitative Services - Coordinated medical or therapeutic services provided to a Member, according to a level of care in which the medical provider and/or licensed mental health professional is licensed, for the purpose of improving the Member's physical and/or psychological/mental functional ability so the Member may independently carry out daily activities. The services are performed in an outpatient setting pursuant to an individualized treatment plan and not requiring the Member's full-time or part-time confinement to a Hospital or Residential Treatment Center.

Partial Hospitalization - Inpatient treatment other than full 24-hour programs in a treatment facility licensed/certified by the State of Mississippi and approved by the Company. Partial Hospitalization is a structured, short-term treatment program that offers nursing care and active treatment in a program that operates at a minimum of six hours per day, five days per week. Members must attend a minimum of six hours per day when participating in a partial hospitalization program. Members are not cared for on a 24-hour per day basis, and typically leave the program each evening and/or weekends. Partial hospitalization treatment is provided by a multidisciplinary treatment team, which includes a licensed mental health professional for mental health and/or substance use conditions. Partial hospitalization is an alternative to acute inpatient hospital care or Residential Treatment Center and offers intensive, coordinated, multidisciplinary clinical services for Members that are able to function in the community at a minimally appropriate level and do not present an imminent potential for harm to themselves or others.

Pediatric Blue Primary Care Home – A partnership between a Member who is younger than 18 years of age and their Pediatric Blue Primary Care Network Provider focused on achieving quality health outcomes based upon an individualized primary care treatment plan. Member's primary care wellness plan is coordinated by the Pediatric Blue Primary Care Network Physician and their health team who are committed to improving Member's overall health and achieving Member's health goals.

Pediatric Blue Primary Care Network Physician – A Physician who is a Network Provider for the purposes of this Benefit Plan, is approved by the Company, and who provides wellness, metabolic management and care coordination for its attributed Members younger than 18 years of age as part of the Pediatric Blue Primary Care Home.

Pediatric Blue Primary Care Network Provider - A Pediatric Blue Primary Care Network Physician or Certified Nurse Practitioner who is a Network Provider for the purposes of this Benefit Plan, is approved and designated by the Company, and who provides wellness, metabolic management and care coordination for its attributed Members younger than 18 years of age as part of the Pediatric Blue Primary Care Home.

Physical Medicine - The modalities, therapeutic procedures, tests and measurements performed by a licensed Physician, licensed Chiropractor, licensed Physical Therapist, licensed Occupational Therapist or other Allied Health Professional (while acting within the scope of his or her license) used to evaluate and treat acute neuromusculoskeletal conditions.

Physician - A Doctor of Medicine, a Doctor of Osteopathy, or a Doctor of Podiatry, legally qualified and licensed to practice medicine and practicing within the scope of his or her license at the time and place service is rendered.

Pre-Certification/Certification - A determination by a Network Provider or Company that an Admission or healthcare service is Medically Necessary as well as meets the Care Management requirements of this Benefit Plan.

Prescription Drug Formulary - A list of Prescription Drugs covered by Company. The Prescription Drug Formulary provides coverage, clinical and cost comparison information to providers servicing Company's Members, and may generate savings from drug manufacturers which are used in the financing of this Benefit Plan.

Prescription Drugs - Drugs that under Federal law may be dispensed only upon a written prescription and which are approved for and indicated by the Food and Drug Administration for the disease or condition being treated. Benefits for Prescription Drugs will be based on the Allowable established by Company. Prescription Drugs include Reference Biologic Medications, Biosimilar Products and Interchangeable Biological Products which are licensed and approved by the Food and Drug Administration.

Prescription Drug Utilization Management - A program which is part of Care Management. Through this program, the Company will determine the Medical Necessity of Prescription Drugs. The Company's determination of Medical Necessity will be based upon established Medical Policy.

Preventive Health Services - Services designed to effectively prevent or screen for a disease for which there is an effective treatment when discovered in an early stage. Preventive Health Services include, but are not limited to:

1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Service Task Force;

2) routine immunizations for children, adolescents, and adults as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention:

3) evidence-informed preventive care and screenings for infants, children and adolescents provided for in comprehensive guidelines supported by the United States Health Resources and Services Administration (HRSA); and

4) evidence-informed preventive care and screenings for women, provided for in comprehensive guidelines supported by the HRSA.

Primary Care Network Physician – A Network Provider who has a Network Provider Agreement with the Company. Primary Care Network Physicians include: family practice, general practice, internal medicine, pediatrics and obstetrics/gynecology.

Prior Authorization - A determination by Company that: (1) the covered service, procedure, supply, equipment or Prescription Drug is Medically Necessary (2) the medical setting, such as the level of care and place of treatment, is the most clinically appropriate for the procedure, service, supply or equipment, or Prescription Drug.

Private Duty Nursing Services - Services of an actively practicing Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) who is unrelated to the patient by blood or

marriage. These services must be ordered by the attending Physician and require the technical skills of an R.N. or L.P.N. in shifts of at least 8 continuous hours.

Prosthetic Appliance - Appliances which replace all or part of a body organ, or replace all or part of the function of a permanently inoperative, absent, or malfunctioning body part.

Provider - A Hospital, Allied Health Facility, Physician, or Allied Health Professional, licensed where required, performing within the scope of license, and approved by Company.

A. **Network Provider -** A Hospital, Physician or Allied Provider who has a Network Provider Agreement with Company pertaining to Covered Services rendered to a Member. A Network Provider may also be a Center of Excellence Provider, Blue Primary Care Network Provider, Blue Specialty Network Provider, Color Me Healthy! Network Provider, or Healthy You! Network Provider based on criteria established by the Company. A Network Provider will file claims for the Member and will not bill the Member for any charges above the Allowable except for any non-covered expenses, any Deductible Amount and Co-payment/Co-insurance amount required by the Benefit Plan.

B. **Non-Network Provider -** A Hospital, Physician or Allied Provider who does not have a Network Provider Agreement with Company.

Payment for Covered Services and supplies, as provided in this Benefit Plan, are limited or not covered when provided by a Non-Network Provider as stated in the Schedule of Benefits section of this Benefit Plan.

Qualified Beneficiaries - For purposes of COBRA only, these are individuals who are entitled to elect COBRA Continuation Coverage as a result of the loss of employer provided group health coverage (known as a "Qualifying Event"). Individuals who may be Qualified Beneficiaries are the spouse and dependent children of a covered employee and in certain circumstances, the covered employee (See General Provisions Section).

Qualifying Event - For purposes of COBRA only, a Qualifying Event is any of the following events that cause a loss of coverage: (1) termination of employment or reduction in hours of employment; (2) death of a covered employee; (3) divorce or legal separation; (4) a covered employee's entitlement to Medicare; (5) a dependent child's loss of dependent status; or (6) loss of coverage due to the employer's filing of a bankruptcy proceeding (See General Provisions Section).

Quantity Limits - Limits on Prescription Drugs based on recommendations from the manufacturers and the U.S. Food and Drug Administration (FDA), as well as accepted medical practices for dosing.

Reference Biologic Medication – The single biological product, already approved by the FDA, against which a proposed Biosimilar Product is compared.

Registered Dietitian - A Registered Dietitian who currently holds a registration from the Commission on Dietetic Registration of The American Dietetic Association.

Rehabilitative Care - The coordinated use of medical, social, educational or vocational services, beyond the Acute Care stage of disease or injury, for the purpose of restoring, keeping, and/or improving the physical functional ability of a patient lost as a result of

disease or injury so that the patient may independently carry out ordinary daily activities. These services may include physical therapy, occupational therapy, and speech therapy.

Residential Treatment Center (RTC) - A specialized level of care health facility providing mental health and/or substance use disorder Residential Treatment Services. The RTC offers 24 hour awake supervision, including at least 8 hours a day nursing and 24 hour nursing availability and psychiatrist visits at least once per week. The staff should include qualified licensed professional counselors, psychiatrists, psychologist, psychotherapists and physicians. The RTC's licensure may differ somewhat by state, and they are typically designated residential, sub-acute, or intermediate care facilities and may occur in care systems that provide multiple levels of care. RTCs are not considered acute-care Hospitals, and must be accredited by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF). RTCs must also be licensed by the Department of Health as a Psychiatric Health Facility (Center), if providing mental health services in the State of Mississippi. The services provided in an RTC are subject to Care Management and must comply with Medical Necessity criteria established by the Company.

Residential Treatment Services - Evidence based multi-disciplinary treatment services for mental health and/or substance use disorders provided in a 24 hour supervised Residential Treatment Center. These services will differ in degree of intensity of service [e.g., number of hours and number of times per week] depending on the nature of the disorder and age of the Member. At a minimum, the individualized services must include: psychiatric/medical evaluation; psychosocial/substance use assessment; clinical assessment; toxicology screening; medication reconciliation; medication monitoring; medical history and physical exam; individual/group/family/support/recovery/12-step therapy; structured therapeutic plan/multi-disciplinary plan; psychiatrist/physician visits; nursing staff on site; and, an initial discharge plan. These services are subject to Care Management and must comply with Medical Necessity criteria established by the Company.

Respite Care - Short-term care at a level comparable to that provided by "caregiver" and approved by Company, which is provided to relieve a person ("caregiver") who is caring for a terminally ill Member at home free of charge.

Self-Administered Drugs - Drugs covered under Prescription Drug Benefits which the Member takes by mouth or otherwise administers to themselves. Such drugs include, but are not limited to: oral medications, subcutaneous injections, suppositories, eye drops, and topical medications.

Special Care Unit - A designated Hospital unit which is approved by Company and which has concentrated all facilities, equipment, and supportive services for the provision of an intensive level of care for critically ill patients.

Specialist - A Network Physician who does not meet the definition of a Primary Care Network Physician or Blue Primary Care Network Provider.

Specialty Services - Treatment and care related to the following services:

A. **Cardiac Care** – including, but not limited to, non-emergent cardiac percutaneous coronary interventions, coronary artery bypass graft surgery, and cardiac valve replacement;

B. **Spine Surgery** – including, but not limited to, discectomy, spinal fusion, and spinal decompression procedures;

C. **Orthopedic Services** – including, but not limited to, shoulder, knee and hip replacement; and

D. Other Specialty Services as defined by the Company.

Specialty Service Area - a geographical service area as defined by the Company.

Speech Therapy - Treatment of a speech impairment resulting from disease or injury. Learning disabilities and developmental problems may qualify for treatment, subject to Medical Policy. This treatment must be provided by a licensed speech therapist and prescribed by a Physician.

Subscriber - An Eligible Person who has satisfied the specifications of this Benefit Plan's Schedule of Eligibility and has enrolled for coverage; also, the person whose name appears on the identification card and to whom Company, at the request of the Group, has issued a Benefit Plan summarizing coverage available under this Benefit Plan.

Substance Use Disorder - The physiological and/or psychological dependence upon or abuse of alcohol, drugs or other chemicals, characterized by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems. This includes the impairment of social or occupational role functioning or both, as described or classified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and which is not otherwise excluded from coverage under this Benefit Plan.

Surgery

A. The performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations, incisional and excisional biopsies and other invasive procedures,

B. The correction of fractures and dislocations,

C. Maternity Care to include vaginal deliveries and caesarian sections.

D. Usual and related pre-operative and post-operative care,

E. Other procedures as defined and approved by Company.

Telemedicine - The delivery of healthcare services such as diagnosis, consultation or treatment through the use of HIPAA-compliant telecommunication systems, including information, electronic and telecommunication technologies, remote patient monitoring services and store-and-forward telemedicine services. Telemedicine, other than remote patient monitoring services and store-and-forward telemedicine services, must be “real-time” audio visual capable.

Telemedicine Services - Covered Services specified in this Benefit Plan for which benefits are available when rendered via HIPAA-compliant interactive electronic and telecommunication technologies. Telemedicine Services include, but are not limited to, consultations and care coordination with Specialists.

Temporomandibular/Craniomandibular Joint Disorder - Disorders resulting in pain and dysfunction of the temporomandibular/ craniomandibular joint which arise out of rheumatic disease, dental occlusive disorders, and internal and external joint stress.

Therapy Service - The following services or supplies ordered by a Physician and used for the treatment of a condition, illness or injury to promote the recovery of the patient.

A. **Chemotherapy -** The treatment of malignant disease by chemical or biological antineoplastic agents.

B. **CAR-T Cell Therapy -** CAR-T cell (chimeric antigen receptor T-cell) therapy is a type of gene manipulation therapy that involves collecting an individual's own T-cells and modifying them to be used as immunotherapy in the treatment of certain hematologic malignancies.

C. **Immunotherapy -** The treatment of disease by inducing, enhancing, or suppressing an immune response.

D. **Radiation Therapy -** The treatment of disease by X-ray, radium, or radioactive isotopes.

E. **Respiratory Therapy -** Therapy utilizing many medically approved modalities to clear the lungs of secretions as well as improve lung function.

See Physical Medicine for Physical Therapy and Occupational Therapy. See separate definition for Speech Therapy.

Transitional Acute Care - Inpatient Acute Care provided for certain complex or chronic conditions, as determined by the Company, following transfer of the Member from a Hospital to a Network facility approved by Company to provide Medically Necessary, clinically appropriate Acute Care services for the purpose of allowing the Member to transition to a lower level of care or to a home setting.

Utilization Management - The evaluation of Medical Necessity, appropriateness and efficiency of the use of healthcare services, procedures and providers according to established criteria and guidelines as defined by the Company.

Article II

Schedule of Eligibility

Eligible Person

Eligible Person is defined as:

1) An employee who has satisfied any probationary period required by Group, not to exceed 90 days, and is actively working at least an average of 30 hours per week or 130 hours per month. An Eligible Person must also be

    a. a citizen or national of the United States,

    b. a non-citizen who is lawfully present in the United States, and is reasonably expected to be a citizen, national, or

    c. a non-citizen who is lawfully present for the entire period for which enrollment is sought.

2) Officers, partners and owners, if working 30 or more hours per week on average and receiving regular compensation from the Employer.

3) Elected officials and appointed officials.

4) An Eligible Person becomes a Subscriber when enrolled for coverage under this Benefit Plan.

For all eligible persons, fees must be collected through payroll deduction.

Employees on mandatory medical leave periods (federal FMLA, state FMLA, etc.) may remain eligible employees for the length of their legally-mandated coverage period. If an employee's employer voluntarily provides medical leaves of absence to its employees, the employer must maintain a documented medical leave of absence policy for an employee to remain eligible for Health and Wellness Benefit Plan coverage during such leave (a voluntary medical leave of absence is a leave of absence that is not required by federal and/or state laws). Regardless of whether the employer's medical leave of absence policy is voluntary or mandatory, Health and Wellness Benefit Plan coverage during a medical leave of absence shall be limited to 12 weeks per 12-month period (or 26 weeks for military entitlement).

Eligible Dependent

Eligible Dependent is defined as follows:

1. The Subscriber's legal spouse.

2. The Subscriber's Dependent children, including: (a) newborn children, (b) step-children, (c) children for whom the Subscriber has been appointed legal guardian by a court of competent jurisdiction, (d) adopted children or children who have been placed by a court of competent jurisdiction in the custody of the Subscriber

for the purposes of adoption, (e) children designated by a court of competent jurisdiction under the terms of a "Qualified Medical Child Support Order (QMCSO) as defined by Section 609(a)(2)(A) of ERISA; (f) children who have been placed in the custody of the Subscriber by a court of competent jurisdiction.

3. A Dependent child must be under the age of 26 in order to be covered under the Benefit Plan.

4. Mentally or Physically Handicapped Dependents - A mentally or physically handicapped child must be incapable of self-sustaining employment, living with the Subscriber in a parent/child relationship and dependent on the Subscriber for more than one half of his or her support. The following guidelines apply to the enrollment of a handicapped child:

    a. A handicapped child may be covered as any other child under this Benefit Plan to age 26. Once the handicapped Dependent reaches the limiting age of 26, a "Request for Coverage for a Mentally or Physically Handicapped Dependent" form must be submitted to extend coverage beyond age 26. This form must be received by Company and approved by the Company.

    b. A Subscriber may not apply for coverage for a handicapped child who is over the limiting age of 26 (as described in subparagraph a above). Handicapped children other than those meeting the above criteria are not considered eligible Dependents for the purposes of this Benefit Plan.

Application for Coverage

1. Every Eligible Person may apply for coverage under this Benefit Plan and may include any Eligible Dependents in such application.

2. The Group will submit any such applications to the Company as a prerequisite to coverage under this Benefit Plan.

3. No person for whom coverage is sought will be covered under this Benefit Plan unless the application for coverage has been accepted by the Company and such acceptance has been evidenced by the issuance of a virtual identification card or other written notice of acceptance. Payment of fees to the Company for any person for whom coverage is sought will not effectuate coverage unless and until the Company's virtual identification card or other written acceptance has been issued, and in the absence of such issuance, the Company's liability will be limited to refund of the amount of fees paid.

4. This Group Benefit Plan and coverage under it will not be issued or renewed unless the percent of Eligible Persons have enrolled as specified in the Employer Application.

Kinds of Coverage

Four tier rate structure:

1. Subscriber-Only Coverage means coverage for Subscriber only.

2. Family Coverage means coverage for Subscriber and one or more Dependents.

3. Subscriber/Spouse Coverage (where available) means coverage for Subscriber and his or her dependent spouse.

4. Subscriber/Child/Children Coverage (where available) means coverage for Subscriber and his or her dependent child or dependent children.

Enrollment Requirements

When an application has been submitted and any fees for coverage have been paid in advance as required by this Benefit Plan, coverage will commence on the following applicable Effective Date.

Note: Enrollment is not complete and coverage does not become effective under any Enrollment opportunity provided for within this section until the Eligible Person has enrolled in *my*Blue®. *my*Blue® is the Company's secure internet portal that provides information regarding Benefits under the Health and Wellness Benefit Plan. Should the Eligible Person fail to register under *my*Blue®, coverage will not become effective and benefits will not be available.

1. Enrollment of a New Group

   An Eligible Person may apply for coverage for himself/herself or himself/herself and any Eligible Dependents during the initial enrollment of a new group. The Effective Date of coverage will be the Group's Effective Date.

2. Enrollment of Newly Eligible Employee

   a) Without a probationary period. If a person becomes an Eligible Person after the Group's Effective Date, and applies for coverage for himself/herself or himself/herself and any Eligible Dependent(s) within 31 days of being first eligible, the Effective Date will be the 1st or 15th (depending on a Group's billing date) following the Eligible Person's date of hire or as specified by the Group and accepted by Company in the Employer Application and Agreement (FOR COVERAGE TO BE EFFECTIVE AS SPECIFIED ABOVE, COMPANY MUST RECEIVE THE APPLICATION WITHIN 31 DAYS OF THE PERSON BEING FIRST ELIGIBLE). If the Eligible Person fails to apply within 31 days of being first eligible, he or she will not be eligible to apply until the Open Enrollment Period defined within this Article.

   b) With a probationary period. If a person becomes an Eligible Person after the Group's Effective Date, and applies for coverage for himself/herself or himself/herself and any Eligible Dependent(s) within 31 days of completion of an established probationary period, the Effective Date will be: 1) the 1st or 15th of the month following the completion of the probationary period; 2) on the 91st day if the Group has elected, within the Employer Application, a 90 day waiting period; or 3) as specified by the Group and accepted by Company in the Employer Application and Agreement (FOR COVERAGE TO BE EFFECTIVE AS SPECIFIED ABOVE, COMPANY MUST RECEIVE THE APPLICATION WITHIN 31 DAYS OF THE PERSON BEING FIRST ELIGIBLE) (Note: The Eligible Person may apply during the established probationary period; however, the effective date of coverage will be

determined as outlined above). If the Eligible Person fails to apply within 31 days of being first eligible, he or she will not be eligible to apply until the Open Enrollment Period defined within this Article.

3. Open Enrollment Periods

   a) The Open Enrollment Period is the 31 day period immediately preceding the Group's renewal date. An Eligible Person (or Subscriber where applicable) who failed to apply for coverage for himself/herself and/or any Eligible Dependent(s) when initially eligible or during a Special Enrollment Period (described below) may apply during the Open Enrollment Period.

   b) To apply during the Open Enrollment Period, the Eligible Person (or Subscriber where applicable) must submit and Company must receive an Enrollment Form or Request for Change Form prior to the end of the 31 day Open Enrollment Period. He or she must elect or change to the appropriate coverage. The Effective Date of coverage will be the Group's renewal date.

   c) If an Enrollment Form or Request For Change Form is not received by Company as specified above, the Eligible Person (or Subscriber where applicable) must wait to apply for coverage for himself/herself and/or any Eligible Dependent(s) during the Group's next Open Enrollment Period or a Special Enrollment Period if a subsequent qualifying event occurs.

4. Special Enrollment Periods

   An Eligible Person may enroll in this Benefit Plan outside the Open Enrollment Period if the Eligible Person or Eligible Dependent qualifies for a Special Enrollment Period as a result of one of the following qualifying events.

   a) Special Enrollment Periods due to loss of other health insurance coverage.

      An Eligible Person and/or an Eligible Dependent who is not enrolled for coverage may enroll in this Benefit Plan during a Special Enrollment Period subject to the following conditions:

      (1) The Eligible Person or Eligible Dependent was covered under another group health plan or other insurance coverage at the time this Benefit Plan was previously offered; and

      (2) The Eligible Person declined coverage for himself/herself and/or his/her Eligible Dependent(s) under this Benefit Plan when initially eligible on the basis of coverage under another group health plan or other health insurance coverage; and

      (3) The loss of coverage under the prior group health plan or other health insurance coverage was due to one of the following conditions:

         (a) Termination of employment, a reduction in the number of hours of employment, termination of employer contributions for the other group health plan, or cessation of Dependent status (such as divorce, legal separation, death or attaining the maximum age to be eligible as a dependent child);

         (b) The exhaustion of coverage under COBRA or the applicable continuation provisions of the Mississippi Code;

(c) Termination of the other plan's coverage, loss of Health Maintenance Organization coverage because he or she no longer resides, lives or works in the service area, exhaustion of the maximum lifetime benefit amount under another group health plan or other health insurance coverage, loss of health insurance coverage under a benefit option offered by a group; or

(d) Loss in coverage under Medicare, TRICARE, or Veterans healthcare programs.

(4) The Eligible Person (or where applicable the Subscriber) will have 31 days from the date of the special enrollment event to enroll in coverage. An Enrollment Form or Request for Change Form, whichever is applicable, must be submitted to and received by the Company within the 31 day period. Written confirmation of prior coverage will be required.

(5) If the Eligible Person submits an Enrollment Form which is received by the Company prior to or on the day of the loss of coverage, the Effective Date of coverage will be the first day of the month following the loss of coverage. If an Enrollment Form is submitted by the Eligible Person and received by Company after the loss of coverage, the Effective Date will be the first day of the first month after the Company received the request for enrollment.

b) Special Enrollment Period for Newly Eligible Dependents

(1) The Subscriber may apply for coverage for a newly Eligible Dependent and other Eligible Dependent(s) following marriage, birth, adoption, placement of a child in foster care, or in accordance with a Guardianship, Custody or Qualified Medical Child Support Order (hereinafter Qualifying Event). The Subscriber must submit and Company must receive a Request for Change Form within 31 days from the date of the Qualifying Event. The Effective Date of coverage for the Eligible Dependent(s) will be the date of the Qualifying Event.

c) Special Enrollment Period for Non-Covered Eligible Person Acquiring a Newly Eligible Dependent

(1) If a non-covered Eligible Person acquires an Eligible Dependent through birth, marriage, adoption, placement in anticipation of adoption, placement in foster care, or a Guardianship, Custody or Qualifying Medical Child Support Order (hereinafter Qualifying Event), the non-covered Eligible Person may apply for coverage for himself, herself, the Eligible Dependent and other Eligible Dependent(s). The non-covered Eligible Person must submit and Company must receive an Enrollment Form within 31 days of the Qualifying Event. The Effective Date of Coverage for the non-covered Eligible Person and the Eligible Dependent will be the date of the Qualifying Event.

d) Special Enrollment Period following loss of coverage or eligibility for premium assistance under the Children's Health Insurance Program or Medicaid

(1) If a non-covered Eligible Person or their Eligible Dependent loses coverage under the Children's Health Insurance Program (CHIP) or

Medicaid, or becomes eligible for premium assistance under the Children's Health Insurance Program (CHIP) or Medicaid, the non-covered Eligible Person may apply for coverage for himself, herself and the Eligible Dependent. The non-covered Eligible Person must submit and Company must receive an Enrollment Form within 60 days after the loss of eligibility under Medicaid or CHIP or becoming eligible for such premium assistance.

(2) The effective date of coverage will be the first day of the first month after the date the Company receives the Enrollment Form.

5. Notice of Enrollment from Mississippi Department of Human Services

Subject to Section 43-13-303 et. seq., Mississippi Code Annotated (Revised), the Mississippi Department of Human Services (hereinafter DHS), may issue a Notice of Enrollment Letter (hereinafter Notice) notifying an employer of his or her duty to enroll certain dependent children. The following guidelines apply to this enrollment process:

a) The Notice must contain all of the following information:

(1) A statement indicating that the employee (Subscriber) has not complied with a prior court order mandating coverage for his or her dependent children under the employer's group health plan and providing the name(s) of the child(ren) to be enrolled.

(2) The DHS case number and name, address and telephone number of the county case worker.

b) A copy of the court order requiring that health coverage be provided to specified dependent children must be attached to the Notice.

c) A Request for Change Form which has been signed by either the employee, custodial parent or the DHS case worker must be submitted to the Company. Note: The Request for Change Form cannot be signed by the employer.

d) Eligibility Guidelines and Effective Dates.

(1) The Effective Date of coverage for dependents enrolling as a result of the Notice is the first or fifteenth of the month (depending on the group's billing date) following the Company's receipt of the completed documentation outlined in subparagraphs a, b and c above.

(2) A Subscriber is not allowed to add other Eligible Dependents which are not listed in the Notice and the corresponding Court Order. The Subscriber may apply for coverage for other Eligible Dependents during the Open Enrollment Period.

(3) The Notice does not create a Special Enrollment Period for an eligible employee. All other non-covered eligible persons are subject to the eligibility provisions outlined in this Benefit Plan.

Article III

Benefits Provided

Payments

1. The terms "pay," "paid," "payment," "payable," as well as similar terms, are found throughout this Benefit Plan. When the aforementioned terms are used with respect to the provision of Benefits, the terms are referencing the Benefits provided by Company, rather than an actual amount paid by Company.

2. Subject to the maximum limitations as well as the terms and provisions of this Benefit Plan, Company will provide Benefits for Covered Services provided that the Covered Services are furnished or rendered prior to the cancellation or termination date of the Member's coverage. Benefits are based on the Allowable minus (a) any applicable Deductible Amount, (b) any applicable Co-payment and/or (c) any applicable Co-insurance.

3. When a Subscriber or Dependent's Network Out-of-Pocket expenses for Network Deductibles, Co-payments or Co-insurance reach the Network Out-of-Pocket amount shown in the Schedule of Benefits, the Company will provide Benefits at 100% of the Allowable incurred for Covered Services, rendered by a Network Provider, during the remainder of the Benefit Period.

4. Any expenses for Covered Services rendered by a Non-Network Provider do not accumulate to the Out-of-pocket amount. The Non-Network Co-insurance for Covered Services still applies after the Out-of-pocket amount is satisfied.

5. If this Benefit Plan replaces previous Company coverage providing comprehensive or major medical Benefits, Co-insurance for Covered Services under previous Company coverage during the current Benefit Period may be used toward satisfying the Network Out-of-pocket amount of this Benefit Plan.

6. Any charges incurred by Member for non-approved days in a Hospital as an Inpatient will not apply toward the Network Out-of-pocket Amount.

7. If applicable, Benefits for Prescription Drugs are subject to a Prescription Drug Deductible.

Article IV

Hospital Benefits

Benefits as specified in the Schedule of Benefits and this Section will be available for the following Covered Services furnished to the patient by a Hospital:

All Hospital Admissions (to include Emergency, Mental Health Disorder, and Substance Use Disorder Admissions) are subject to Care Coordination as outlined in Article XIII, Care Management.

In addition, at regular intervals during the Inpatient stay, the Network Provider or the Company will perform a Continued Stay Review to determine the appropriateness of continued hospitalization through Care Coordination.

Only certain Covered Services will be covered in a Hospital Setting. Company may require a Prior Authorization for Hospital Services if the Covered Service can be provided in a lower place of treatment (i.e. Ambulatory Surgical Facility, Center of Excellence, or office). If Prior Authorization from Company is not obtained, coverage shall not be provided for Covered Services provided in a place of treatment other than the lower place of treatment.

Inpatient Bed, Board and General Nursing Service

1. In a private room or room with two or more beds.
2. In a Special Care Unit for a critically ill Member requiring an intensive level of care.

Other Hospital Services (Inpatient and Outpatient)

1. Use of operating, delivery, recovery, and treatment rooms and equipment.
2. Drugs, Medical Prescription Drugs, biologics, and medicines including take-home Prescription Drugs.
3. Blood transfusions, including the cost of whole blood, blood plasma and expanders, processing charges, administrative charges, equipment and supplies.
4. Anesthesia, anesthesia supplies and anesthesia services rendered by a Hospital employee.
5. Medical and surgical supplies, casts, and splints.
6. Diagnostic Services rendered by a Hospital employee.
7. Therapy Services rendered by a Hospital employee.
8. Psychological testing and Psychotherapy when ordered by the attending Physician and performed by an employee of the Hospital.

Inpatient Rehabilitation Services

Benefits as specified in the Schedule of Benefits and this section will be available for Inpatient Rehabilitation Services.

1. Benefits for Inpatient Rehabilitation Services will only be provided when Covered Services are determined to be Medically Necessary by Company.

2. Covered Services must be recommended by the Member's treating Physician. The attending or discharging physician must certify that the Member is medically stable, has a good prognosis and has rehabilitation potential.

3. A treatment plan outlining the goals of the Inpatient Rehabilitation Services must be submitted to Company by the Network Provider before the initiation of the service.

    a. The attending or discharging physician must write an order to consult Inpatient Hospital Rehabilitation services signifying that a determination was made that the Member requires and can be expected to benefit from the extensive interdisciplinary multidisciplinary team approach. The treatment must be reasonable and necessary in terms of efficacy, frequency, duration and amount of treatment for the condition with a realistic goal that the Member will achieve minimal assistance to stand-by assistance in self-care and activities of daily living to allow the Member to return home or to another community setting.

    b. The Member's condition requires 24-hour rehabilitation nursing and 24-hour availability of a physician with special training in the field of rehabilitation or daily physician and/or psychiatrist visits for mental health and/or substance use disorders.

    c. The Member must be able to follow simple commands and participate for a minimum of five (5) days per week in at least three (3) hours of daily physical, occupational, speech-language pathology or mental health and/or substance use therapies.

4. The Covered Services must have Care Management approval and comply with Medical Policy established by the Company.

5. Benefits are limited to 30 Inpatient days per Member per Calendar Year except as provided under Article IX, Mental Health and Substance Use Disorder Benefits. Covered Services are provided in free standing rehabilitation facilities or rehabilitation units in acute care hospitals.

6. The facility providing the Inpatient Rehabilitation Services must be accredited by The Joint Commission or DNV Healthcare, Inc. and the Commission on Accreditation of Rehabilitation Facilities (CARF). A facility providing mental health and/or substance use Inpatient Rehabilitation Services which is not a unit of an acute care Hospital must be accredited by The Joint Commission or CARF.

7. The facility providing the Inpatient Rehabilitation Services must be a Network Provider. No Benefits will be provided when a Member receives services from a Non-Network Provider except for Mental Health and Substance Use Disorder Benefits.

Article V

Ambulatory Surgical Facility Benefits

Benefits as specified in the Schedule of Benefits and this Section will be available for the following Covered Services furnished to the patient by an Ambulatory Surgical Facility:

A. Services consisting of routine pre-operative laboratory procedures directly related to the surgical procedure.

B. Pre-operative preparation.

C. Use of Facility (operating rooms, recovery rooms, and all surgical equipment).

D. Anesthesia, drugs and surgical supplies.

E. Implants, prostheses and nourishments.

Only certain Covered Services will be covered in an Ambulatory Surgical Facility. Company may require a Prior Authorization if the Covered Service can be provided in a lower place of treatment (i.e. office). If Prior Authorization from Company is not obtained, coverage shall not be provided for Covered Services provided in a place of treatment other than the lower place of treatment.

Article VI

Surgical and Medical Benefits

Benefits as specified in the Schedule of Benefits and this Section will be available for the following surgical and medical services furnished to a Member by a Physician or Allied Health Professional.

Surgical Services

1. Surgery

    a. The Allowable for Inpatient Surgery includes all pre- and post-operative medical visits.

    The pre- and post-operative period is defined and determined by Company and is that period of time which is appropriate as routine care for the particular surgical procedure.

    b. For Surgery performed in a Physician's office, Benefits are allowed for the surgical procedure and surgical tray. No Benefits are allowed for the office facility charge unless the (1) Company has an agreement with the office facility; and (2) the office facility has been approved by Company.

    When performed in the Physician's office, the Allowable for the Surgery includes the office visit. No additional Benefits are allowed toward charges for office visits on the same day as the Surgery.

2. Assistant at Surgery

    a. The Assistant at Surgery is a professional (Physician, Physician Assistants, Certified Nurse Practitioners or Certified Registered Nurse First Assistants) who assists the primary surgeon in the performance of a covered surgical procedure. Benefits for an Assistant at Surgery will be provided only if Company determines the Medical Necessity of an Assistant at Surgery is warranted and the assistant is acting within the scope of his or her license.

    b. The Physician Assistant, Certified Nurse Practitioner, or Certified Registered First Assistant must be an employee of the primary surgeon’s clinic.

    c. When the need for an Assistant at Surgery is documented to be Medically Necessary, Benefits will be based on the Allowable for the type of provider assisting at the surgery.

3. Anesthesia

    a. Benefits will be provided for general anesthesia service when requested by the attending Physician and performed by a Certified Registered Nurse Anesthetist or Physician, other than the operating Physician or the assistant, for covered surgical services. Benefits will also be provided for other forms of anesthesia services as defined and approved by Company.

b. Benefits for administration of anesthesia will be based on the Allowable for anesthesia administration as determined by the primary surgical procedure performed.

c. Supervision of anesthesia administration includes pre-operative, operative, and post-operative supervision of anesthesia care. Benefits for supervision of anesthesia administration will be less than those provided for administration of anesthesia. These Benefits will be based on the Allowable for anesthesia supervision as determined by the primary surgical procedure performed.

Inpatient Medical Services

Subject to provisions as specified in the sections pertaining to Surgery and maternity in this Benefit Plan.

1. Inpatient Medical Care Visits
2. Concurrent Care
3. Consultation

Outpatient Medical Services

1. Office
2. Home and Other Outpatient visits for examination, diagnosis, and treatment of an illness or injury. These Benefits do not include routine pre- and post-operative medical visits for Surgery or maternity.
3. Consultation

Diagnostic Services

Benefits will not be provided when a Member receives Diagnostic Services from a Non-Network Diagnostic Service Facility.

Therapy Services

Benefits for Radiation Therapy, Chemotherapy, Immunotherapy, CAR-T Cell Therapy, and Respiratory Therapy are subject to the following provisions:

(a) Therapy Services will only be provided when Covered Services are Medically Necessary.

(b) Company may require a treatment plan, outlining the goals of therapy, mode of therapy, and duration of therapy, to be submitted by the Provider prior to the initiation of treatment.

(c) Benefits for Immunotherapy and CAR-T Cell Therapy will not be provided unless Medically Necessary subject to Medical Policy and a treatment plan submitted by the Network Provider and approved by the Company prior to the initiation of treatment. Immunotherapy and CAR-T Cell Therapy services must be received from a Network Provider designated and approved by the Company where the Company has a contract in place with the Network Provider, either directly or through BlueCard®, for the specific Immunotherapy and CAR-T Cell Therapy service.

(d) No Benefits will be provided for Therapy Services when a Member receives services from a Non-Network Provider.

(e) No Benefits will be provided for Gene Manipulation Therapy, except federally approved CAR-T Cell Therapy from a Network Provider approved by the Company.

Physical Medicine

1. Benefits for Physical Medicine are subject to the following provisions:

   (a) Physical Medicine will only be provided when Covered Services are Medically Necessary.

   (b) A treatment plan outlining goals of therapy, mode of therapy and duration of therapy must be submitted to Company by the Provider prior to the initiation of treatment.

   (c) Benefits for Physical Medicine are limited to the number of visits per Calendar Year as specified in the Schedule of Benefits or when maintenance level of therapy is attained (whichever the Member reaches first). A maintenance program consists of activities that preserve the Member's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur.

   (d) Visit limits apply to Physical Medicine visits in the home and at the Network Allied Specialist's office or facility.

   (e) No Benefits will be provided for services rendered by Non-Network Physical Therapists, Occupational Therapists, or Chiropractors. In addition, no Benefits will be provided for Physical Medicine when services are provided by a Non-Network Provider.

   (f) Physical Medicine for the treatment of Temporomandibular Joint Disorder must be Prior Authorized and is subject to Medical Policy.

2. Based on Medical Necessity and the treatment plan submitted by the Provider, Company may also limit:

   (a) the maximum number of modalities per visit,

      i. Limited to three (3) modalities per visit.

(b) the maximum number of visits per week, and

(c) the maximum number of weeks per calendar year.

3. Benefits for Physical Medicine are subject to the terms and conditions of this Benefit Plan.

Diabetes Treatment

Benefits as specified in the Schedule of Benefits and this section will be available for Diabetes Treatment. These Benefits will be subject to the following provisions:

1. Member must have a diagnosis of Diabetes to be eligible for Benefits.

2. Member may be required to enroll in Company's Color Me Healthy! program.

3. Benefits will be provided for equipment and supplies used in connection with the monitoring of blood glucose and insulin administration. Benefits for home glucose monitors will be limited to one (1) monitor every two Calendar Years.

4. Benefits will be provided for Diabetes Self-Management Training in an outpatient, inpatient or home health setting. Benefits for Diabetes Self-Management Training will be limited to six (6) hours per Calendar Year.

    a. Training/education must be provided by a Certified Diabetes Educator (CDE) who is approved by the Company and is appropriately certified, licensed or registered to practice in the State of Mississippi.

    b. Medical nutrition therapy must be provided by a Registered Dietitian (RD) appropriately licensed or registered to practice in the State of Mississippi and who is approved by the Company.

    c. All Covered Services provided by a Certified Diabetes Educator or Registered Dietitian must be based on nationally recognized standards, including, but not limited to, the American Diabetes Association guidelines.

5. Benefits will be provided for a dilated eye exam for Members with a diagnosis of Diabetes. Dilated eye exams are limited to one (1) exam per Calendar Year.

6. Benefits will be provided for preventive or routine foot care rendered to a Member by a Network Provider practicing within the scope of his/her license and who is approved by the Company. The Member must have a diagnosis of Diabetes or be receiving treatment for a metabolic, neurologic, or peripheral vascular disease. Preventive or routine foot care is limited to one (1) visit per Calendar Year.

7. Benefits will be provided for care of corns, bunions, calluses, or debridement of nails rendered to a Member by a Provider practicing within the scope of his/her license and who is approved by the Company. The Member must have a diagnosis of Diabetes with complications of neuropathy or peripheral vascular disease, or be receiving treatment for a metabolic, neurologic, or peripheral vascular disease, making such care Medically Necessary.

Surgery for Mastectomy and Reconstruction of the Breast

When the Company determines the Medically Necessity of medical and surgical benefits with respect to a Member's mastectomy, Benefits will be provided for breast reconstruction when such Covered Service is elected by the Member. In accordance with the terms and provisions of this Benefit Plan, including but not limited to the Network or Non-Network Medical Deductible Amounts, as applicable, Out-of-Pocket Amount and applicable Benefit and Co-insurance amounts, the following Benefits will be provided:

1. Reconstruction of the breast on which the mastectomy has been performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. Prostheses and physical complications all stages of mastectomy, including lymphedemas.

Outpatient Cardiac Rehabilitation

Benefits as specified in the Schedule of Benefits and this section will be provided for Outpatient Cardiac Rehabilitation (Phase II).

1. No Benefits will be provided unless the Member receives Care Management approval for Covered Services from Company.

2. Covered Services must be rendered by a facility that is a Network Provider and holds a current certification from the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR). No Benefits will be provided when a Member receives services from a Non-Network Provider.

3. Benefits must be recommended by the Member's treating Physician.

4. A treatment plan outlining the goals of the Outpatient Cardiac Rehabilitation must be submitted to Company by the Network Provider before the initiation of the services.

5. Outpatient Cardiac Rehabilitation Services must be initiated within 3 months after the Member's discharge from the Hospital.

6. The number of visits for Outpatient Cardiac Rehabilitation Services is based on the severity of the Member's condition; however, Covered Services cannot exceed 36 visits per Member per Calendar Year.

7. No Benefits will be provided for Pulmonary Rehabilitation except as provided in Article XII.

Sleep Studies

Benefits as specified in the Schedule of Benefits and this section will be available for sleep studies to assist in the diagnosis of sleep disorders.

1. Benefits for sleep studies will only be provided when Covered Services are determined to be Medically Necessary by Company.

2. Covered Services must be recommended by the Member's treating Physician.

3. Supervised polysomnography, multiple sleep latency testing (MSLT) and monitoring of wakefulness testing (MWT) as well as any other Covered Services approved by Company must be performed through an approved sleep disorder center. Sleep disorder centers are facilities in which illnesses are diagnosed through the study of sleep.

4. The sleep disorder center must be either affiliated with a hospital or freestanding and be accredited as a sleep disorder center by the American Academy of Sleep Medicine (AASM).

5. Benefits for home/unattended sleep studies may be provided if determined to be Medically Necessary and performed by a Network Provider accredited by the AASM for home sleep apnea testing.

6. Network accredited facilities must adhere to Company's Medical Policy in order to support Medical Necessity for the sleep study.

7. No Benefits will be provided when a Member receives services from a Non-Network Provider.

Autism Spectrum Disorder Services

Benefits as specified in this section will be available for Applied Behavioral Analysis (ABA) services for Autism Spectrum Disorders (ASD) including Medically Necessary assessments, evaluations, or tests performed for diagnosis of ASD. ABA will be available for a Member who is diagnosed with ASD when considered by the Company to be Medically Necessary for the treatment of ASD. These Benefits will be subject to Medical Necessity and Company's Medical Policy.

Speech Therapy, Physical Therapy and Occupational Therapy will be rendered as specified in the Schedule of Benefits as Habilitative Care when considered Medically Necessary by the Company and as specified in Company's Medical Policy.

Article VII

Maternity Benefits

Benefits as specified in the Schedule of Benefits and this Section will be available for maternity care furnished by a Hospital, Physician, Allied Health Professional, and Allied Health Facility. Certain clinical assessments to ensure delivery at the appropriate Network Hospital apply to maternity Benefits. See Article XIII, Care Management for additional information.

A. For a patient who is covered as a Subscriber or Dependent of a Subscriber and, whose coverage remains in effect at the time services are furnished in connection with her pregnancy:

    1. Surgical and Medical Services.

        a. Initial office visit.

        b. Diagnostic Services.

        c. Delivery, including necessary pre-natal and post-natal care.

        d. Interruptions of Pregnancy.

            (1) Miscarriage.

            (2) Medically Necessary abortion required in order to preserve the life or physical health of the mother.

    2. Hospital Services required in connection with pregnancy and interruptions of pregnancy as described above.

B. For the treatment of illness, prematurity, postmaturity, or congenital conditions for an ill newborn within thirty-one (31) days after birth. This Benefit is available only when the Subscriber provides coverage for Dependent(s) under this Benefit Plan.

C. For a newborn who is covered at birth as a Dependent:

    1. Surgical and Medical Services.

        a. Circumcision during the newborn’s post-delivery stay.

    2. Hospital Services.

        a. Circumcision during the newborn's post-delivery stay.

    3. Newborn Well Baby Care

        a. Physician’s initial examinations of a well newborn or, when delivery is by cesarean section, one Consultation for standby resuscitation and infant care in the operating room by a Physician other than the operating surgeon. Benefits will also be provided for subsequent visits by the Physician while the well newborn is in the hospital with the mother. These Benefits will not extend beyond the mother’s stay.

        b. Routine Hospital nursery care of a well newborn for the mother’s authorized routine length of stay for an uncomplicated vaginal delivery or caesarian section.

Article VIII

Other Covered Services, Supplies, or Equipment

Benefits as specified in the Schedule of Benefits and this Section will be available for the following surgical and medical services furnished by an Allied Provider or Physician, where applicable.

Ambulance Service Benefits

Benefits as specified in the Schedule of Benefits will be available for the following covered Ambulance Services when Medically Necessary:

1. Medically Necessary transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured;

    a. from the place where the Member is injured by accident or stricken by illness to the nearest Hospital where treatment is to be given;

    b. from a Hospital where a Member is an Inpatient to another Hospital or freestanding facility to receive specialized diagnostic or therapeutic services not available at the Hospital of origin and back to the Hospital of origin after such services have been rendered;

    c. from a Hospital to another Hospital when the discharging Hospital has inadequate treatment facilities and the receiving Hospital has appropriate treatment facilities;

    d. to a Hospital or Ambulatory Surgical Facility for Outpatient care of an Accidental Injury or a Medical Emergency,

2. Ambulance Service also includes transportation by air ambulance when, as determined by Company, the Member's condition or urgency of needed medical care precludes travel by surface transportation. Air ambulance service is helicopter transportation to the nearest institution with appropriate facilities for treatment of the Member's injury or illness. Fixed wing air transportation is for long distance travel only and is not ordinarily considered to be an air ambulance service.

3. Ambulance Service Benefits will not be provided for a Member's comfort or convenience.

Durable Medical Equipment

1. Benefits for Durable Medical Equipment will be subject to Medical Policy.

2. Benefits for Durable Medical Equipment will only be provided when:

    a. The equipment is prescribed by a Physician.

    b. The equipment does not serve as a comfort or convenience item.

    c. The equipment is certified by Company.

3. Determination of Benefits for Durable Medical Equipment will be based on the following:

    a. The equipment must meet all Durable Medical Equipment requirements of Company. The equipment must meet the following criteria:

        (1) can withstand repeated use,

        (2) is primarily and customarily used to serve a medical purpose,

        (3) is generally not useful to a person in the absence of illness or injury,

        (4) is appropriate for use by the Member.

    b. The equipment must meet all Medical Necessity requirements. Therefore, the equipment must be:

        (1) appropriate for the symptoms and provided for the diagnosis or direct care and treatment of the Member's condition, illness, disease or injury.

        (2) in accordance with accepted standards of medical practice.

        (3) the most appropriate supply or level of service that can safely be provided to the Member.

4. Benefits for rental or purchase of Durable Medical Equipment.

    a. Benefits for the rental of Durable Medical Equipment will be based on Company's rental Allowable (but not to exceed the purchase Allowable).

    b. At the option of Company, Benefits will be provided for the purchase of Durable Medical Equipment, appropriate supplies, and oxygen required for therapeutic use.

    c. Benefits based on the Allowable for standard equipment will be provided toward any deluxe equipment when selected by the Member solely for the Member's comfort or convenience.

    d. Benefits for deluxe equipment based on the Allowable for deluxe equipment will only be provided when documented to be Medically Necessary.

    e. Accessories and medical supplies necessary for the effective functioning of covered Durable Medical Equipment are considered an integral part of the rental or purchase allowance.

f. Benefits will be provided for the repair, adjustment or replacement of purchased Durable Medical Equipment or components only within a reasonable time period of purchase subject to the lifetime expectancy of the equipment.

5. Limitations in connection with Durable Medical Equipment.

   a. Benefits will not be provided during rental for repair, adjustment, or replacement of components and accessories necessary for the effective functioning and maintenance of covered equipment as this is the responsibility of the Durable Medical Equipment supplier.

   b. Benefits will not be provided for Durable Medical Equipment used in Infusion Therapy except as provided in Article VIII, Infusion Therapy.

   c. Benefits will not be provided for equipment where a commonly available supply or appliance can substitute to effectively serve the same purpose.

   d. Benefits will not be provided for construction costs to the Member's residence to accompany the Durable Medical Equipment.

   e. Benefits will not be provided for hot tubs, swimming pools, whirlpools, lift chairs, and air purifiers.

   f. No Benefits will be provided for Durable Medical Equipment obtained from a Non-Network Provider.

Dialysis Treatment

1. Benefits for Dialysis Treatment are subject to the following provisions:

   (a) Dialysis Treatment will only be provided when Covered Services are Medically Necessary.

   (b) Company may require a treatment plan, outlining the goals of therapy, mode of therapy, and duration of therapy, to be submitted by the Provider prior to the initiation of treatment.

   (c) No Benefits will be provided for Dialysis Treatment when a Member receives services from a Non-Network Provider.

Infusion Therapy

1. Benefits as specified in the Schedule of Benefits and this section will be available for Medically Necessary Infusion Therapy in the Member's home or in an outpatient setting or facility which is a Network Provider.

2. Covered Services are limited to drugs, intravenous solutions, Durable Medical Equipment, pharmacy compounding and dispensing services, fees associated with drawing blood for the purpose of monitoring response to therapy, therapist services, ancillary medical supplies, and nursing visits, including initiation of

Infusion Therapy, intravenous restarts and Emergency care when Medically Necessary to provide Infusion Therapy.

3. Limitations in connection with Infusion Therapy

    a. No Benefits are payable under any other section of this Benefit Plan for services, drugs, equipment or supplies used in Infusion Therapy, except as provided for in this section.

    b. No Benefits are payable for the supervision of Self-Administered Drugs or family-administered drugs.

    c. No Benefits are payable for any charges for nursing visits, care, services or supplies associated with Infusion Therapy other than as stipulated in the per day Allowable.

    d. No Benefits are payable for other services required to administer Infusion Therapy in the home setting but which do not involve direct patient contact, including but not limited to delivery charges and record keeping.

    e. No Benefits will be provided for Infusion Therapy provided by Non-Network Providers.

Prosthetic Appliances

Benefits as specified in the Schedule of Benefits and this Section will be available for the purchase of Prosthetic Appliances as approved by Company. These Benefits will be subject to the following:

1. No Benefits will be provided for fitting or adjustments as this is included in the Allowable for the Prosthetic Appliance.

2. Benefits will be provided for the repair or replacement of the Prosthetic Appliance after a reasonable length of time. This time period will be determined by Company.

3. Benefits based on the Allowable for standard equipment will be provided toward any deluxe equipment when selected by the Member solely for the Member's comfort or convenience.

4. Benefits for deluxe equipment based on the Allowable for deluxe equipment will only be provided when documented to be Medically Necessary.

5. No Benefits will be provided for Prosthetic Appliances which are required by the Member for the specific purpose of participating in recreational or sporting activities.

6. No Benefits will be provided unless a Medical Necessity Certificate is completed by the prescribing Physician.

Orthotic Devices

Benefits in this section and as specified in the Schedule of Benefits will be available for the purchase of Orthotic Devices as approved by Company. These Benefits will be subject to the following:

1. No Benefits will be available for fitting or adjustments as these are included in the Allowable for the Orthotic Device.

2. Benefits will be provided for repair or replacement of the Orthotic Device only within a reasonable time period of purchase subject to the lifetime expectancy of the equipment.

3. Benefits based on the Allowable for standard equipment will be provided toward any deluxe equipment when selected by the Member solely for the Member's comfort or convenience.

4. Benefits for deluxe equipment based on the Allowable for deluxe equipment will only be provided when documented to be Medically Necessary.

5. No Benefits are available for supportive devices for the foot.

6. Orthotic Devices must be certified with Company.

7. Benefits will not be provided for deluxe or customized devices if Company has already provided Benefits for standard devices.

8. No Benefits will be provided for Orthotic Devices which are required by the Member for the specific purpose of participating in recreational or sporting activities.

9. No Benefits will be provided unless a Medical Necessity Certificate is completed by the prescribing Physician.

Prescription Drug Benefits

Based on the Allowable established by Company, Benefits as specified in the Schedule of Benefits will be available for drugs that under Federal law may be dispensed only by written prescription and which are approved for and indicated by the Food and Drug Administration for the disease or condition being treated except for drugs used in the treatment of cancer provided that such drug is recognized for treatment of the specific type of cancer for which the drug was prescribed in one of the standard reference compendia or in the medical literature. The drugs must be dispensed on or after the Member's Effective Date by a licensed pharmacist at a Network Pharmacy upon the prescription of a Physician as well as conform to the dosing schedule as prescribed by the Food and Drug Administration as well as accepted medical practices for dosing. Medical Prescription Drugs are not dispensed by a Network Pharmacy. These Benefits will be subject to the following:

1. Prescription Drugs are subject to Care Management to include Prior Authorization which may be required prior to Benefits being provided.

2. Benefits will not be provided, regardless of Medical Necessity, for the following: Any Prescription Drug not included in the Prescription Drug Formulary, Medical Prescription Drug Formulary, Maintenance Drug Formulary or Disease Specific Drug Formulary.

3. The Member must satisfy the Prescription Drug Deductible outlined in the Schedule of Benefits before Company will provide Benefits for Prescription Drugs in Categories Two, Three and Four.

4. Only those Prescription Drugs which are determined by Company to be Medically Necessary for the treatment of illness or injury will be covered.

5. Benefits for Prescription Drugs will be limited to maximum increments of a 30-day supply per dispensing except a 90-day supply under Maintenance Drug Benefits.

6. Benefits will be provided for injectable insulin and necessary insulin syringes.

7. Members will not receive Benefits for refills of Prescription Drugs until 75% of the last dispensed 30 day supply or 90 day supply is exhausted by the Member.

8. Due to the nature and use of certain Prescription Drugs, Company classifies these drugs as Infusion Therapy. Infusion Therapy drugs are not considered retail Prescription Drugs. See Article VIII, Infusion Therapy.

9. As specified in the Schedule of Benefits in the Prescription Drug section, Prescription Drug Benefits will be provided for diabetic supplies (e.g. blood testing supplies, urine testing supplies and lancets) approved by the Company.

10. Based on the Allowable established by Company, Benefits as specified in the Schedule of Benefits will only be available for Disease Specific Drugs that meet the definition of Disease Specific Drugs located in Article I and are listed in the Disease Specific Drug Formulary. These Benefits will be subject to the following:

    a. Drugs for the prevention or treatment of complex and chronic complex conditions must be prescribed by a Network Physician and dispensed by either a Network Disease Specific Pharmacy or the Member's non-pharmacy Network Provider.

    b. No Benefits will be provided for Disease Specific Drugs unless the Network Provider:

        (1) Receives Prior Authorization based upon Medical Policy criteria from Company.

        (2) Provides clinical management of the Disease Specific Drug.

        (3) Documents and provides to Company the continued Medical Necessity of the Disease Specific Drug as well as the clinical outcomes of the Member's treatment with the Disease Specific Drug.

    c. These Disease Specific Drugs will not be considered retail Prescription Drugs.

11. Benefits will not be provided for the following: FDA approved Prescription Drugs utilized for cosmetic purposes (Examples include, but are not limited to, growth hormones and botulinum toxin (Botox®).

12. No Benefits will be provided for Compound Prescription Drugs.

13. Benefits for covered Prescription Drugs may be limited to one Prescription Drug per therapeutic class within a day supply limit.

14. As part of the Company's Generic First Program, certain brand name drugs as determined by Company 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 a brand drug. The following conditions must be met:

    a. The Member has tried and failed therapy with a proven cost-effective first-line drug approved by Company, and is verified by the Company's claims system, or

    b. The Member's Provider has documented and provided to the Company the failure of a proven cost-effective first-line drug approved by the Company, or

    c. The Member's Provider has documented and provided to the Company information to support that the member has a hypersensitivity or contraindication that would prohibit therapy on the cost-effective first-line drug, or

    d. The Member's Provider has documented sufficient Medical Necessity to support the utilization of another drug in lieu of the cost-effective first-line drug, and is approved by the Company's clinical staff.

15. Maintenance Drugs are available only through Community PLUS Maintenance Pharmacies. If a Maintenance Drug prescription is presented to a Community PLUS Pharmacy which is not a Maintenance Pharmacy, Benefits will only be available for a 30 day supply.

16. Benefits for Prescription Drugs are subject to Quantity Limits and/or day limits and Medical Policy. No Benefits will be provided for Prescription Drugs prescribed or dispensed beyond the Quantity Limits and/or day limits.

17. Certain Prescription Drugs are subject to clinically appropriate duration of use restrictions based upon the usual course of treatment.

18. Certain Prescription Drugs, for a reasonable period of time due to Medical Necessity and/or Medical Policy, may not be considered Covered Services subject to Benefits unless they are prescribed by a Company designated Network Provider and dispensed by a Company designated Community PLUS Pharmacy.

19. Benefits may be reduced if the Member uses a drug manufacturer's coupon which reduces or eliminates the Member's liability.

20. Benefits will not be provided if the Member receives financial assistance from a drug manufacturer or if the Member has no obligation to pay for the Disease Specific Drug or Medical Prescription Drug.

21. Subject to Prior Authorization and as necessary along with trial use of a lower cost alternative, Benefits may be available for a Category Four Prescription Drug 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.

22. Benefits for Prescription Drugs will not be provided for Prescription Drugs that are not obtained from the appropriate place of service. (i.e., some Prescription Drugs are covered only if: a) dispensed or administered in a Provider's office or in an outpatient setting; or b) dispensed from a Network Pharmacy.)

23. Medical Prescription Drugs are subject to a) the applicable cost-sharing for medical Benefits as outlined in the Schedule of Benefits; b) the Prescription Drug Benefits provisions in this Article; c) Medical Policy; d) the Medical Prescription Drug Formulary; and e) the Prescription Drug Benefits provisions in the Limitations and Exclusions Article.

Company utilizes various pharmaceutical management procedures. These include but are not limited to: the Generic First Program, Prescription Drug Utilization Management, Medical Policy criteria, prescription drug class and quantity limitations, and the use of a Prescription Drug Formulary. To learn more about these pharmaceutical management procedures, please refer to the Explanation of Pharmaceutical Management Procedures at www.bcbsms.com.

Speech Therapy

1. Benefits as specified in the Schedule of Benefits and this section will be available for Speech Therapy. These Benefits are subject to the following provisions:

    a. Speech Therapy will only be provided when Covered Services are Medically Necessary.

    b. A treatment plan, outlining the goals of therapy, mode of therapy and duration of therapy, may be required by Company prior to the Provider initiating treatment.

    c. Speech Therapy, as limited in the Schedule of Benefits and this section, is covered up to the Benefit maximum when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur.

Hospice Care

Benefits as specified in the Schedule of Benefits and this Section will be available for Hospice Care as approved by Company. These Benefits are subject to the following provisions:

1. Benefits are limited to 6 months per the lifetime of the Member and are subject to Care Management.

2. The Hospice Care must be prescribed by a Network Physician.

3. The Hospice Care must be provided by a Network Provider.

4. The Member's Network Physician must: (a) submit a life expectancy certification to certify that the Member is not expected to live more than 6 months; and (b) submit a written Hospice Care plan or program. All Covered Services for Hospice Care must be approved in writing by Company or provided through Care Coordination.

5. Members who elect Hospice Care under this Benefit Plan are not entitled to other Benefits under this Benefit Plan for the terminal illness while the hospice election is in effect.

6. Covered Services do not include bereavement counseling, pastoral counseling, financial or legal counseling or custodial care.

7. The Hospice treatment program must:

    a. Meet the standards outlined by the National Hospice Association,

    b. Be recognized as an approved Hospice program by Company,

    c. Be licensed, certified and registered as required by state law, and

    d. Be directed by a Network Physician and coordinated by a Registered Nurse, with a treatment plan that provides an organized system of hospice facility care; uses a hospice team; and has round-the-clock care available.

8. Hospice Care is considered a Non-covered Service when rendered by a Non-Network Provider.

Pediatric Vision Services

Benefits are available only for Members up to age 19 and will be available through the month in which the Member turns 19 years of age. Benefits are provided for an annual comprehensive routine eye examination and one pair of eyeglasses, as specified in the Schedule of Benefits, (if medically necessary). Covered lenses include plastic lenses (including scratch-resistant coatings) and polycarbonate single vision, bi-focal, tri-focal and lenticular lenses. Pediatric Vision Services are considered Non-covered Services when rendered by a Non-Network Provider.

Contact lenses are not covered when vision can be corrected with eyeglasses.

Telemedicine

Telemedicine Benefits will be covered, as approved by Company, when Covered Services are performed in accordance with Medical Policies. Telemedicine must be rendered via HIPAA-compliant interactive electronic and telecommunication technologies. For Real-time interactive Telemedicine Services, services must be "real-time" audio visual capable. Real-time audio Telemedicine Services, as defined by statute and regulation, may be covered for certain services when the Member does not have access to real-time audio visual communication technology.

Article IX

Mental Health and Substance Use Disorder Benefits

Benefits for treatment of Mental Health Disorders as shown in the Schedule of Benefits are subject to Care Management and Medical Necessity, as established by the Company.

Substance Use Disorder Benefits as shown in the Schedule of Benefits are subject to Care Management and Medical Necessity, as established by the Company.

A. As defined in this Benefit Plan, Benefits for Mental Health Disorders and Substance Use Disorders will be provided at a percentage of the Allowable, as specified in this Benefit Plan.

B. Inpatient Care Benefits

   Company will provide Benefits based on the Allowable for Covered Services provided to a Member for Inpatient services and Partial Hospitalization.

C. Residential Treatment Center Benefits

   Company will provide Benefits based on the Allowable for Covered Residential Treatment Services.

D. Outpatient Care Benefits

   Company will provide Benefits based on the Allowable for Covered Services provided to a Member for Outpatient services. Outpatient services are those services which are received in a Hospital, an Outpatient treatment facility or other appropriate setting licensed or certified by the State of Mississippi and approved by Company.

E. Mental Health and Substance Use Disorder Benefits do not include those items listed in the Limitations and Exclusions Article.

All services are subject to Care Management, Medical Necessity and appropriateness of care.

Article X

Temporomandibular/ Craniomandibular Joint Disorder

Benefits as specified in the Schedule of Benefits and this Section will be available for Surgery and Diagnostic Services of the temporomandibular/craniomandibular joint as approved by Company. These Benefits will be subject to the following:

A. Benefits for office visits, consultations, Physical Medicine, Surgery and Diagnostic Services of the temporomandibular/craniomandibular joint will be provided. Benefits will be provided for intra-oral removable prosthetic devices and appliances, including the fabrication, insertion and adjustments.

B. Medical Necessity documentation and a treatment plan, including charges for each service, must be submitted to and approved by the Company prior to the commencement of treatment.

C. Prior Authorization is required for temporomandibular/craniomandibular joint disorder Benefits. No benefits will be provided unless the Network Provider receives Prior Authorization from Company.

D. No Benefits will be provided for temporomandibular/craniomandibular joint disorder when a Member receives services from a Non-Network Provider.

Article XI

Dental Care and Treatment/ Dental Surgery

Benefits will be provided only for the following services or procedures:

A. Excision of tumors or cysts (excluding dentigerous cysts) of the jaws, gums, cheeks, lips, tongue, roof and floor of mouth.

B. Dental Care and Treatment including Surgery and dental appliances required to correct Accidental Injuries of the jaws, cheeks, lips, tongue, roof of mouth and sound natural teeth (For the purposes of this section, sound natural teeth are those which are capped, crowned or attached by way of a crown or cap to a bridge. Sound natural teeth may have fillings or a root canal). Accident means any injury caused by external force. The act of chewing does not constitute an injury caused by external force.

C. Excision of exostoses or tori of the jaws and hard palate.

D. Incision and drainage of abscess and treatment of cellulitis.

E. Incision of accessory sinuses, salivary glands, and salivary ducts.

F. Surgical procedures related to micrognathism (overbite) and macrognathism (underbite) when such services are provided pursuant to an accidental injury or when such services are recommended by a physician or dentist for the treatment of severe craniofacial anomalies when Medically Necessary as determined by Medical Policy established by the Company.

G. When a Member has a nondental organic disease or condition which makes an alternative treatment setting (hospital or ambulatory surgical facility) necessary to safeguard health while undergoing treatment for non-covered Dental Care and Treatment, Benefits will be provided for room, board, and other necessary services if Company determines that: (1) the alternative treatment setting is Medically Necessary and (2) the Covered Services required to treat the non-dental organic disease or condition are Medically Necessary. No Benefits will be provided for the alternative setting or the Covered Services needed to treat the nondental organic disease unless the Member's dentist receives Prior Authorization from Company of the Medical Necessity of the alternative setting and the Covered Services needed to treat the non-dental organic disease.

H. Pediatric Dental Services:

   1. Services are limited to Members under the age 19 and will be provided through the month in which the Member turns 19 years of age.

      a. Benefits will be provided for preventive and diagnostic dental care as listed below.

i. Bitewing X-Rays - as needed, but no more frequently than once every six months;

ii. Complete Mouth X-Ray, Panoramic X-Ray, and Periapical X-Ray - as needed, but no more frequently than once every twenty-four (24) months;

iii. Prophylaxis- one every six months; must be separated by six full months;

iv. Fluoride Treatment – limited to one each 6 month period;

v. Space Maintainers – limited to permanent teeth through age 15;

vi. Sealants – covered up to age 14, every 36 months

b. Benefits will also be provided for restorative, endodontic, periodontic and surgical dental services as indicated below:

i. Amalgam, Silicate, Sedative and Composite Resin Fillings including the replacement of an existing restoration;

ii. Stainless steel crowns to posterior and anterior teeth;

iii. Full cast noble metal crowns to posterior and anterior teeth;

iv. Porcelain crowns to anterior teeth only;

v. Porcelain fused to high noble metal crowns to anterior teeth only;

vi. Simple extraction;

vii. Extraction of an impacted tooth;

viii. Pulpotomy, pulpectomy and root canal;

ix. Gingivectomy, gingivoplasty and gingival curettage.

x. Surgical extraction of an erupted tooth.

2. Subject to Prior Authorization, Benefits will be provided for anesthesia and for associated facility charges when the Mental Health or physical condition of the Member requires dental treatment to be rendered under physician-supervised general anesthesia.

3. No Benefits will be provided for orthodontics, dentures, occlusion reconstruction, or for inlays unless such services are provided pursuant to an accidental injury as described above or when such services are recommended by a physician or dentist for the treatment of severe craniofacial anomalies or full cusp Class III malocclusions.

Article XII

Organ and Tissue Transplant Benefits

Subject to the provisions of the Schedule of Benefits and this section, Benefits will be provided for treatment and care related to or required as a result of the transplant procedures outlined below:

A. This Benefit Plan covers the following organ transplant procedures: (1) Renal, (2) Heart, (3) Heart/Lung, (4) Liver, (5) Bone Marrow, and (6) other organ transplant procedures which Company determines to be effective procedures through Medical Policy in effect at the time the services were rendered (which includes but is not limited to the review of peer review literature, second opinions and administrative policy in existence at the time of the request for the procedure). Procedures of this type will be considered on an individual basis. The aforementioned transplant procedures are subject to the following provisions:

    1. The Member must receive Covered Services from a Network Provider approved and designated by Company for the particular transplant surgery; and

    2. The Member's Network Provider must receive Prior Authorization from Company.

B. Reasonable and necessary expenses for lodging (hotels, motels, apartments or short-term house rentals) and transportation to and from the transplant facility designated by Company for the covered transplant procedure from the patient's primary residence (air, rail and/or bus), as well as daily mileage to and from temporary lodging and the Company designated facility will be covered for a transplant recipient and one Company-approved companion for an adult or two Company-approved companions for Members under 21 years of age or if the transplant involves a living donor. Travel and lodging Benefits will be subject to the following:

    1. Travel and Lodging Travel Policy located on bcsbms.com.

    2. Covered transplant services must be performed by a transplant facility designated by Company.

    3. The transplant, including pre-transplant evaluation, must be prior approved by Company.

    4. Member must receive Prior Authorization from Company for covered travel and lodging expenses.

    5. Designated facility location criteria must be met:
        a. For residents of Mississippi, the Company designated facility is located outside the State of Mississippi and is more than 50 miles from the Member's primary residence.

b. For non-Mississippi residents, the Company designated facility is located more than 50 miles from the Member's primary residence, unless a shorter distance is Medically Necessary, as determined by Company.

6. Travel and lodging expenses are limited to $200 per day cumulative for the patient and approved companions (excluding airfare) with an aggregate limit for the patient and approved companions of $10,000 per Covered transplant episode of care (pre-transplant evaluation and the actual transplantation, which begins five days prior to the transplant and ends when the member returns to primary residence after discharge from the Company designated facility).

C. Benefits as specified in this Section C will be provided for solid organ and tissue transplant living donor coverage. If a covered solid organ or tissue transplant is provided from a living donor to a human transplant recipient:

1. Donor coverage includes expenses for:

a. A search for matching tissue, bone marrow or organ.

b. Donor's transportation subject to Section B, above, and the Travel and Lodging Travel Policy located on bcsbms.com.

c. Charges for removal, withdrawal and preservation.

d. Donor's hospitalization.

2. When only the recipient is a Member, the donor is entitled to the Benefits of this Benefit Plan which are not available to the donor from any other source. This includes, but is not limited to, other insurance coverage, or other Blue Cross or Blue Shield coverage or any governmental program.

3. When the donor is a Member, the donor is entitled to the Benefits of this Benefit Plan. No Benefits will be provided to the Non-Member transplant recipient.

4. If any organ or tissue is sold rather than donated to the Member recipient, no Benefits will be payable for the purchase price of such organ or tissue; however, other costs related to evaluation and procurement are covered.

D. Benefits will be provided for Outpatient Pulmonary Rehabilitation for a Member determined by Company to be an appropriate candidate for lung transplantation subject to the following:

1. No Benefits will be provided unless the Member receives Care Management approval for Covered Services from Company.

2. Benefits will be provided for preoperative conditioning for a Member determined by Company to be an appropriate candidate for lung transplantation.

3. Covered Services must be rendered by a facility that is a Network Provider and that holds a current certification from the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR). No Benefits will be provided when a Member receives services from a Non-Network Provider.

4. Benefits must be recommended by the Member's treating Physician.

5. A treatment plan outlining the goals of the Outpatient Pulmonary Rehabilitation must be submitted to Company by the Network Provider before the initiation of the services.

6. The number of visits for Outpatient Pulmonary Rehabilitation Services is based on the severity of the Member's condition; however, Covered Services may not exceed 36 visits per Member per Calendar Year.

Article XIII

Care Management

A. Care Management will review and determine whether services provided, or to be provided, are Medically Necessary, provided in the most appropriate, quality and cost effective setting and are Covered Services under this Benefit Plan. Care Management includes, but is not limited to, the following: (1) Utilization Management (2) Case Management (3) Disease Management; and (4) Prescription Drug Utilization Management.

B. Certain Benefits will only be provided when the Member receives Covered Services from Network Providers that are designated by the Company as a Center of Excellence, Blue Primary Care Network Provider, or are privileged / credentialed and approved by the Company for the Covered Services.

C. Based upon a Member's health risks, a Member may be required to enroll in a Care Management program and perform activities under that program.

Referral to Providers

Company or the Member's Blue Primary Care Network Provider may refer the Member to a Network Provider designated as a Center of Excellence or which is privileged / credentialed and approved by the Company, for care, treatment services or supplies. When Company, in conjunction with the Member's Blue Primary Care Network Provider or treating Physician, refers the Member to such a designated Network Provider, notification of the referral will be provided to the Member (Member's representative), the Blue Primary Care Network Provider or treating Physician and other Physicians as appropriate. If the Member chooses to receive services from a Provider other than the Provider to whom the Member was referred, no Benefits will be provided for such services.

Utilization Management

1. Certification/Care Coordination of Elective and Emergency Admissions

    a. When the Member uses a Network Provider, it is the responsibility of the Physician or Hospital, to electronically provide Certification to/notify Company of any elective, Emergency or non-Emergency Inpatient Hospital Admission and to coordinate with Company regarding the Member's care throughout the Hospital Admission to ensure the services rendered to the Member are Medically Necessary and are provided in the most appropriate, quality and cost effective setting. It is also the responsibility of the Hospital to notify Company and coordinate with Company whether additional days of Inpatient care are needed beyond the amount originally deemed Medically Necessary. The Network Provider must coordinate all Inpatient transfers with Company.

    b. When the Member uses a Non-Network Provider, it is the sole responsibility of the Member to ensure that his/her Non-Network Physician or Hospital, notifies Company of any Emergency, non-Emergency or elective Inpatient Hospital Admission. Company must be notified prior to the Admission

regarding the nature and purpose of any Elective Admission or non-Emergency Admission to a Hospital's Inpatient department. The most appropriate setting for the elective service and the appropriate length of stay will be agreed upon when the Hospital Inpatient setting is documented to be Medically Necessary. Company must be notified of all Emergency Inpatient Hospital Admissions within one (1) working day of the Emergency Admission. In the event that the end of the notification period falls on a holiday or weekend Company must be notified on its next working day. Additionally, the Member's care must be coordinated with Company when additional days of Inpatient care are needed beyond the amount originally deemed Medically Necessary.

c. When the Member uses a Non-Network Provider and when clinically appropriate, Company may require member to be transferred to a Network Provider.

d. The Company monitors its Members for potential pregnancy complications. A maternity risk assessment is required by Network Providers for all pregnant Members during the first trimester of pregnancy. Maternity risk assessments for those Members who are identified by the Network Provider to be at high risk for developing complications during pregnancy are provided to Company for initiation of Case Management. Based upon the pregnancy risk, Care Management will work with the Network Provider and the Member to ensure that delivery occurs at the appropriate Network Hospital. The Company requires the Network Provider to provide notification of maternity admissions.

e. Discharge Planning

   i. Discharge planning begins at the time a Member is admitted to the Hospital. Discharge planning identifies the needs of the Member and prepares for a safe and timely discharge from the Hospital. Discharge planning also ensures that resources for continuation of care and support to Members are provided to prevent unnecessary readmissions. Discharge planning completed by the Network Provider includes:

      a) evaluating the Member's risk of readmission and needs after discharge,

      b) determining the clinically appropriate services to allow the Member to be discharged to a lower level of care or to the home and to determine any services which may be Medically Necessary post-discharge,

      c) coordinating and arranging for those Covered Services 2 days prior to discharge (when possible), and

      d) educating Members and their caregivers on their condition, medications, treatments, expected next level of care, and post-discharge Covered Services to be received.

   ii. Transitional Acute Care - Benefits for Transitional Acute Care may be available when rendered by a Network Provider approved by the Company and in accordance with Medical Policy. A treatment plan outlining the goals of the Transitional Acute Care must be submitted by

the Network Provider to the Company and coordinated with Care Management before the initiation of the services. No Benefits will be provided for Covered Services unless the Member's care is coordinated with the Company.

2. Prior Authorization of Services

For certain services, a Prior Authorization is required before the services are rendered.

a. Outpatient Services

The Company may require the Network Provider or Member to obtain Prior Authorization for certain diagnostic, surgical or other Covered Services as defined by the Company. The Company may require Prior Authorization when Covered Services can be provided in a lower place of treatment setting based upon Medical Necessity and the Company's Medical Policy.

b. Solid Organ and Tissue Transplant

No Benefits will be provided unless a Prior Authorization is obtained from Company and services are rendered by a Network Provider that has been approved by Company. Company will be advised of the proposed transplant Surgery prior to Admission and a request for Prior Authorization will be filed with Company. Company will be provided with adequate information so that it may verify coverage, determine that Medical Necessity is documented, and approve of the Provider at which the transplant Surgery will occur. Company will forward authorization to Member and Providers. Travel and lodging expenses related to covered transplants, including pre-transplant evaluation, must receive Prior Authorization.

c. Infusion Therapy

The Member's attending Network Physician or the approved Network Infusion Therapy Provider is required to obtain Prior Authorization for all Infusion Therapy Services and supplies prior to the initiation of any Infusion Therapy services. Only those services furnished after Prior Authorization has been approved will be considered for Benefits. Benefits will not be allowed for services furnished prior to Prior Authorization. Infusion Therapy is considered a Non-covered Service when rendered by a Non-Network Provider.

d. Disease Specific Drugs

When the Member uses a Network Provider who prescribes a Disease Specific Drug, it is the responsibility of the Network Provider to obtain Prior Authorization from Company for the disease specific drug. No Benefits will be provided for the Disease Specific Drugs unless the Network Provider receives Prior Authorization from Company and the drug is issued by a Disease Specific Pharmacy.

e. Prescription Drugs

1. As a part of Care Management, Company may require Prior Authorization of certain Prescription Drugs, to determine if the drug is the most

appropriate product for the Member's specific illness, injury, or disease state. Company may also require the Member to comply with other Care Management requirements for Benefits to be provided for certain Prescription Drugs, including, but not limited to, the submission of a treatment plan by the prescribing provider to include the completion of a risk assessment with the Member.

2. When the Member uses a Network Provider who prescribes one of the identified Prescription Drugs, it is the sole responsibility of the Network Provider to obtain Prior Authorization from Company. No Benefits will be provided for the drug unless the Network Provider receives Prior Authorization from Company. Certain Prescription Drugs are subject to clinically appropriate duration of use restrictions based upon the usual course of treatment.

3. When the Member uses a Non-Network Provider who prescribes one of the identified Prescription Drugs, it is the sole responsibility of the Member to ensure that the Non-Network Provider obtains Prior Authorization from Company. No Benefits will be provided for the drug unless Member receives Prior Authorization from Company.

4. Benefits for Prescription Drugs are subject to Quantity Limits and/or day limits and Medical Policy. No Benefits will be provided for Prescription Drugs prescribed or dispensed beyond the Quantity Limits and/or day limits.

f. Home Health

Home Health may be available through the Company's Care Management Program when provided by a Network Provider and Prior Authorization is received from Company. Home Health is not available if provided by a Non-Network Provider or if Prior Authorization is not approved.

3. Certification of Durable Medical Equipment

a. All Durable Medical Equipment submitted for Benefits requires a Medical Necessity Certificate completed by the prescribing Physician that documents:

1. Prescribed equipment,

2. Medical Necessity of the equipment, and

3. Required time period for use.

b. Certain Durable Medical Equipment will require periodic re-certification during use to evaluate significant therapeutic improvement in the Member's condition in order to determine the continued Medical Necessity for the equipment.

c. Requests for deluxe items require documentation of Medical Necessity for deluxe features (including mechanical or electrical features). Benefits for deluxe equipment will only be provided when Medically Necessary.

d. No benefits will be paid for Durable Medical Equipment from a Non-Network Provider.

4. Utilization Management decisions are based solely upon appropriateness of care and service and the existence of coverage. Company does not reward Providers or other individuals for issuing denials of coverage. Utilization Management decision makers are not provided financial incentives or encouraged to make decisions to lower utilization.

Case Management

The coordination of a comprehensive plan of action for Members with complex healthcare needs. Members qualify for Case Management based on various clinical criteria including diagnosis, severity and length of illness, and proposed treatment. Case managers collaborate with Members, their families, and Network Providers to promote care in the most cost effective setting, and facilitate efficient, appropriate and cost effective care. The goal of Case Management is to provide effective, appropriate and quality management of high risk, high cost and/or catastrophic cases. In administering Case Management, Company will utilize the benefits specified in this Benefit Plan.

Disease Management

Coordinated healthcare interventions and communications for Members with conditions in which patient self-care efforts are significant. Disease Management supports the Network Provider/Member relationship and plan of care, emphasizes prevention and utilizes evidence-based practice guidelines.

1. Company identifies Members who would qualify for Disease Management programs based on selected disease states.

2. Under the Company Disease Management Programs, Member will be required to enroll into a health management program designed to help manage moderate to high risk disease states.

Prescription Drug Utilization Management

The Company's Prescription Drug Utilization Management Program includes Prescription Drug Formulary, Medical Prescription Drug Formulary and Disease Specific Drug Formulary management, Generic First, Prescription Drug compliance and concurrent and retrospective reviews for drug interactions and clinical appropriateness.

Telemedicine

Telemedicine Benefits will be covered, as approved by the Company, when Covered Services are performed in accordance with Medical Policies.

Clinical Trials

Benefits for routine patient costs associated with an approved Clinical Trial may be available through the Company's Care Management Program for Clinical Trials as they are defined by the Patient Protection and Affordable Care Act. Benefits for Clinical Trials are not available if the services are not Medically Necessary.

An approved Clinical Trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following:

1. A federally funded or approved trial;

2. A clinical trial conducted under an FDA investigational new drug application; or

3. A drug trial that is exempt from the requirement of an FDA investigational new drug application.

Routine patient costs generally include all items and services consistent with the coverage provided under the Plan for a qualified individual who is not enrolled in an approved Clinical Trial. Routine patient costs do not include the following:

1. The cost of the investigation item, device or services;

2. The cost of items and services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management;

3. The cost for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Article XIV

Limitations and Exclusions

Benefits will not be provided for the following:

1. Incremental nursing charges which are in addition to the Hospital's standard charge for Inpatient Services.

2. The amount of charges for luxury accommodations or any accommodations in any Hospital or Allied Health Facility provided primarily for the patient's convenience which exceeds the Allowable for a standard Hospital room.

3. Bed and Board in any other room at the same time Benefits are provided for use of a Special Care Unit.

4. Any Prescription Drug and Medical Prescription Drug not included in the Prescription Drug Formulary, Maintenance Drug Formulary, Medical Prescription Drug Formulary or Disease Specific Drug Formulary.

5. Prescription Drugs and Medical Prescription Drugs determined by Company not to be Medically Necessary for the treatment of illness or injury. These drugs include but are not limited to the following:

    a. Drugs used for cosmetic purposes or weight reduction.

    b. Any drug not proven effective in general medical practice.

    c. Investigative drugs and drugs used other than for the FDA approved diagnosis except for drugs used in the treatment of cancer provided that such drug is recognized for treatment of the specific type of cancer for which the drug was prescribed in one of the standard reference compendia or in the medical literature.

    d. Fertility drugs.

    e. Minerals and vitamins (Exception: pre-natal vitamins).

    f. Nutritional supplements.

    g. Drugs that do not require a prescription.

    h. Contraceptive devices (Exception: prescription contraceptives including Birth Control Pills, Norplant, Depro Provera, Intrauterine Devices (IUD), Diaphragms, and Plan B as required by the Patient Protection and Affordable Care Act).

    i. Prescription Drugs and Medical Prescription Drugs if an equivalent product is available over the counter.

    j. Refills in excess of the number specified by the Physician or any refills dispensed more than one year after the date of Physician's original prescription.

k. Certain brand name drugs that require trial usage of a generic alternative, Interchangeable Biological Product or Biosimilar Product before Benefits are available for the brand name drug.

l. Compound Prescription Drugs.

m. A Disease Specific Drug unless the drug is dispensed by a Network Disease Specific Pharmacy or non-pharmacy Network Provider approved by Company. The Network Provider must receive Prior Authorization from the Company. The drug must meet the definition of Disease Specific Drug and must be listed in the Disease Specific Drug Formulary.

n. A Disease Specific Drug or Medical Prescription Drug if the Member receives financial assistance from a drug manufacturer or if the Member has no obligation to pay for the drug.

o. Benefits may be reduced if the Member uses a drug manufacturer's coupon which reduces or eliminates the Member's co-pay.

p. Prescription Drugs and Medical Prescription Drugs where Prior Authorization is required in order for Benefits to be provided and Prior Authorization is not obtained.

q. Infant formulas used as a substitute for breastfeeding.

r. Medical Food administered enterally or orally except as covered under Medical Policy.

s. Prescription Drugs and Medical Prescription Drugs for which Benefits are sought by the Member when the Member has failed to comply with the Company's Prescription Drug Care Management requirements with regard to the Prescription Drugs and Medical Prescription Drugs.

t. Prescription Drugs and Medical Prescription Drugs when not provided in the appropriate place of service.

u. Provider administration or supervision of Self-Administered Drugs in the home or healthcare/clinical setting.

6. Outpatient Occupational Therapy, except as provided through Physical Medicine.

7. For treatment related to sex transformations, sexual function, sexual dysfunctions or inadequacies regardless of Medical Necessity, unless required by law.

8. Elective abortions including, however not limited to, the Member's request for payment of prescription abortifacients (Exception: Upon proper documentation from the Member's Provider, Company may determine the elective abortion procedure was due to an instance of rape or was Medically Necessary in order to preserve the life or physical health of the mother, unless otherwise prohibited by law).

9. Services and supplies related to infertility, artificial insemination, intrauterine insemination and in-vitro fertilization regardless of any claim of Medical Necessity.

10. Provider services or supplies rendered or furnished prior to the Member's Effective Date or subsequent to Member's termination date.

11. Charges for services paid or payable under Medicare Parts A or B when the Member has Medicare coverage.

12. Provider services, supplies, or charges to the extent payment has been made or is available under any other contract issued by this or any other Blue Cross or Blue Shield Company, or to the extent provided for under any other group Benefit Plan.

13. Acupuncture, anesthesia by hypnosis, or charges for anesthesia for non-covered services.

14. Cosmetic Surgery, Cosmetic Services, and any complications resulting from Cosmetic Surgery or Cosmetic Services. Cosmetic Services include, but are not limited to, dermal fillers, laser vein treatment, laser hair removal, laser tattoo removal, cosmetic removal of moles & skin tags, dermabrasion, chemical peel, and electrolysis.

15. Services or expenses for which the Member has no legal obligation to pay, or for which no charge would be made if the Member had no health coverage.

16. Services or supplies which are not prescribed by or performed by or upon the direction of a Provider.

17. Services or supplies rendered by Providers other than those specifically covered by this Benefit Plan.

18. Any treatment, procedure, facility, equipment, drug, device, or supply not yet recognized as accepted medical practice for the treatment of the condition being treated, and therefore, not considered Medically Necessary.

19. Any injury, illness or condition for which a claim has been or will be pursued under any worker's compensation laws. If no claim has been or will be pursued or where there is ultimately no recovery of any type under the applicable worker's compensation laws, Benefits of this Benefit Plan will be available (see Article XV, Subrogation-Work Related).

20. Any injury growing out of an act or omission of another party for which a claim or recovery is or will be pursued. If no claim or recovery is or will be pursued, Benefits otherwise will be available under the terms of this Benefit Plan (see Article XV, Subrogation-Third Party).

21. By any governmental Hospital such as a charity Hospital, mental institution or sanatorium, except in those cases where enforcement of this exclusion would be prohibited by Federal law or the laws of the State of Mississippi.

22. Diseases contracted or injuries sustained as a result of war, declared or undeclared, or any act of war.

23. Care received from a dental or medical department maintained by or on behalf of an employer, a mutual Benefit association, labor union, trust, or similar person or group.

24. Care rendered by a Provider for himself or herself or by a Provider who is a first degree relative of the Member by blood or marriage or who regularly resides in the Member's household.

25. Personal comfort, personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, shower chairs or personal fitness equipment.

26. Charges for telephone Consultations, failure to keep a scheduled visit, completion of a claim form, or to obtain medical records or information required to adjudicate a claim(s).

27. For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, care of corns, bunions (except capsular or bone Surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except for preventive or routine foot care rendered to a Member with a diagnosis of Diabetes or being treated for a metabolic, neurologic or peripheral vascular disease. Preventive or routine foot care is limited to the Covered Services specified in Article VI or as stated in Medical Policy.

28. Any surgical procedure that is performed in order to correct a visual acuity defect that can be corrected by contact lens or glasses is not eligible for coverage.

29. Travel, whether or not recommended by a Physician, except as specified under Ambulance Services Benefits and Organ Transplant Benefits.

30. Weight reduction programs or treatment for obesity including any Surgery for morbid obesity or for removal of excess fat or skin following weight loss, regardless of Medical Necessity, or Services at a health spa or similar facility. This Limitation and Exclusion does not apply to Preventive Health Services subject to the Preventive Health Services Medical Policy established by the Company.

31. Treatment of any Member in the custody of any law enforcement entity or confined in a prison, jail, or other penal institution.

32. Dental Care and Treatment, Dental Surgery, and dental appliances except as specified in this Benefit Plan.

33. For persons 19 years of age and older, benefits will not be provided for eyeglasses, contact lenses, eye exercises, orthoptic therapy or eye care due to decreased visual acuity or other visual complaints to determine the refractory state of the eye or eyes for the prescribing or fitting of glasses or contact lenses or orthoptic therapy. For individuals under the age of 19, benefits will not be provided for: vision training; special lens designs or coating, other than scratch resistant coating for plastic lens; replacement of lost eyewear; plano lenses; or two pairs of eyeglasses in lieu of bifocals.

34. Home Health services provided by a Home Health Agency except as specified in this Benefit Plan.

35. Nursing home care, custodial care, skilled nursing, long term acute care, assisted living, or extended care facility services, regardless of the level of care required or provided.

36. Respite Care.

37. Industrial testing, job screenings or self help programs (including, but not limited to stress management programs).

38. Work hardening programs.

39. Any care or service not specified as a Covered Service.

40. Supplies or equipment used or related to Infusion Therapy except as provided in Article VIII, Infusion Therapy.

41. Care of a newborn not covered at birth as a Dependent except as otherwise required by law with regard to an ill newborn.

42. Provider services or supplies which are not documented to be Medically Necessary as determined by Company.

43. Inpatient Hospital services and supplies for Rehabilitative Care and treatment except as provided in this Benefit Plan (See Hospital Benefits).

44. School, camp, work, and sports physicals, disability examinations, immunizations required for travel or school, and health counseling related to travel.

45. Preventive or wellness care provided at a worksite or school, or by a Certified Nurse Mid-wife, and preventive or wellness services except as provided by this Benefit Plan.

46. For reversal of a voluntary sterilization procedure.

47. Counseling services such as career counseling, marriage counseling, divorce counseling, parental counseling, and job counseling.

48. Services for anger management, hypnotherapy, yoga, animal-assisted therapy, acupuncture, harmonic resonance therapy, nutritional counseling, biofeedback, didactic group education, relaxation therapy, individual psychodynamic therapy, unstructured group therapy, or confrontation therapy as a principal treatment approach.

49. Charges or services related to situation or environmental change(s).

50. Facilities or settings such as therapeutic community, therapeutic group homes, apartment living associated with treatment, sober living houses, day-care, school settings, Oxford House models, half-way houses and home-based settings.

51. Court-ordered treatment determined to not be Medically Necessary.

52. Any programs performed and/or offered by a school, including educational programs, required by federal or state law to be performed and/or offered by schools, including, but not limited to, Individualized Education Programs, Special Education Services, and Individuals with Disabilities Education Improvement Act programs, Attention Deficit Disorder Classrooms, Autism Spectrum Disorders Classrooms or Applied Behavioral Analysis (ABA).

53. Treatment for behavioral disorders, learning disabilities or intellectual disabilities which do not qualify as Habilitative Care.

54. Services and supplies provided by recreational, therapeutic or educational camps or programs, including, but not limited to, weight loss camps, wilderness therapy camps, boot camps, Outward Bound programs and boarding schools, which do not utilize a multidisciplinary team that includes psychologists, psychiatrists, pediatricians, and licensed therapists who are involved daily in the care of the Member and do not meet standards for certification as a Residential Treatment Center or quality of care standards for medically supervised care provided by licensed mental health professionals. This exclusion includes any services provided in conjunction with, or as a part of, such programs or camps.

55. Organ and tissue transplants (autologous and allogeneic) except as provided in Article XII.

56. Services, care, treatment or supplies which are furnished or rendered after the cancellation or termination date of the Member's coverage (whether or not such services, care, treatment or supplies are for or related to a condition, disease, ailment or injury which commenced before or existed on the termination date of the Member's coverage).

57. Pre-Admission Testing.

58. Private Duty Nursing.

59. Drugs that are prescribed by a Provider in order to enhance the Member's performance in certain activities (example: blood enhancing drugs).

60. Dental Implants, including, but not limited to, the fixture, abutment, and prosthesis.

61. Hot tubs, swimming pools, whirlpools, lift chairs, and air purifiers, regardless of the Provider's recommendation.

62. For alterations or structural changes to the Member's home, auto or personal property to accommodate any Durable Medical Equipment. Equipment that does not meet the Company's definition of Durable Medical Equipment will also be excluded for Benefits.

63. Research and testing utilized for determining the cause of a miscarriage or a spontaneous abortion.

64. Charges for all medical complications which arise as the result of the Member receiving non-covered medical, surgical or diagnostic services. Examples of non-covered medical, surgical or diagnostic services include, but are not

limited, to gastric bypass surgery, liposuction, cosmetic surgery, and elective abortions.

65. Charges for braces or any surgery for micrognathism and macrognathism when not Medically Necessary or solely for cosmetic purposes.

66. Illness or injury which is caused by the Member's unlawful possession of any item or substance or possession of any item or substance for an unlawful purpose.

67. Any hearing aids (air or bone conduction), speech generating devices, or listening devices, or for examination or fitting regardless of Medical Necessity.

68. Telemedicine Services except as provided in Article VIII and subject to Medical Policy.

69. In a Specialty Service Area, Specialty Services will only be covered by a Center of Excellence Network Provider or a Blue Specialty Network Provider.

70. Clinical Trials performed by Non-Network Providers or if the Member receives financial assistance from third parties.

71. Services provided pursuant to any direct primary care agreement, fee-for-service agreement, or similar arrangement in which the Member directly pays a health care provider a fee in exchange for the provision of medical services that are not to be billed to any insurance company or other third party.

72. Services provided solely to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought.

73. Genetic testing, even if Medically Necessary, performed by a Provider who is not certified by the College of American Pathologists (CAP) and Clinical Laboratory Improvement Amendments (CLIA) Certified.

74. Services provided by Non-Network Independent Laboratories.

75. Medical marijuana, unless required by law.

76. Travel and lodging expenses for organ and tissue transplants that do not meet the criteria set forth in Article XII.

77. Gene Manipulation Therapy. This exclusion does not apply to federally approved CAR-T Cell Therapy from a Network Provider approved by the Company.

Article XV

General Provisions

This Benefit Plan

1. This Benefit Plan, the Group Application, Company Acceptance, Subscriber application, and the attached amendments, endorsements, and riders, if any, constitute the entire contract between the parties.

2. Except as specifically provided herein, this Benefit Plan will not make Company liable or responsible for any duty or obligation which is imposed on the employer by federal or state law or regulations. To the extent that this Benefit Plan may be a welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Group will be the administrator of such welfare benefit plan and will be solely responsible for meeting any obligations imposed by law or regulation on the administrator of the welfare benefit plan, except those specifically undertaken by Company herein.

3. Company will not be liable for or on account of any fault, act, omission, negligence, misfeasance, malfeasance or malpractice on the part of any Hospital or other institution, or any agent or employee thereof, or on the part of any Physician, Allied Provider, nurse, technician or other person participating in or having to do with the care or treatment of Member.

4. Company does not insure against any condition, disease, ailment or injury but only provides Benefits for Covered Services which are furnished by a Provider to the Member during his or her effective dates of coverage under this Benefit Plan.

5. The Prescription Drug Formulary, Disease Specific Drug Formulary and Medical Prescription Drug Formulary may generate savings from drug manufacturers. These savings are generated from Prescription Drug claims, Disease Specific Drug claims and Medical Prescription Drug claims. Any savings as a result of the Prescription Drug Formulary, Disease Specific Drug Formulary and Medical Prescription Drug Formulary are utilized in the financing of this Benefit Plan. A Member's Co-insurance and/or Co-payment for the Prescription Drug, Disease Specific Drug and Medical Prescription Drug is based on the cost of the drug before Company receives the savings. The Group acknowledges that savings resulting from the Prescription Drug Formulary, Disease Specific Drug Formulary and Medical Prescription Drug Formulary will be used to finance this Benefit Plan and will not be provided directly to the Group with the limited exception of certain Disease Specific Drugs which remit directly to the Group.

Benefit Plan Changes and Certified Agent's Limitation of Authority

1. Company reserves the right to change the amount of payment from/by the Group upon not less than sixty (60) days' notice to the Group and to modify terms of this Benefit Plan upon not less than thirty (30) days' notice to the Group. No change or waiver of any Benefit Plan provision will be effective until approved by

Company's chief executive officer (or as is designated in the Company's Bylaws) and such approval is attached hereto. No agent of Company has the authority to change this Benefit Plan or to waive any of its provisions.

2. THE CERTIFIED AGENT HAS NO AUTHORITY TO INTERPRET, WAIVE, ALTER OR CHANGE THE BENEFIT PLAN OR ANY OF ITS PROVISIONS. IF THE MEMBER HAS ANY QUESTIONS, INCLUDING CONTRACT TERMS, COVERAGE OR BENEFIT QUESTIONS, THE MEMBER SHOULD CONTACT COMPANY. THE CERTIFIED AGENT HAS NO AUTHORITY TO BIND COMPANY WITH ANY ANSWER HE OR SHE MAY GIVE.

*my*Blue®

*my*Blue® is a secure internet portal that provides access to Member information including, but not limited to, benefits, claims, explanation of benefits, your virtual identification card, payment and billing along with various health and wellness information. Member acknowledges that benefits and claims information will be available through the *my*Blue® website and agrees that Company will not provide Member with paper explanation of benefits or benefit information. Further, the Company will communicate with Member and provide notices to Member through *my*Blue® and/or email and/or text as opposed to paper mailings. The Member will communicate with Company as requested through *my*Blue® for Company programs including, but not limited to, Disease Management Programs and Appeals.

Certificates or Booklets and Identification Cards

Company will issue to the Group, for delivery to Subscribers, certificates or booklets which describe this Benefit Plan's Benefits and the procedures for obtaining Benefits. Company will issue to the Member a virtual identification card via *my*Blue. In the event of a conflict between this Benefit Plan and the certificates or booklets, the terms of this Benefit Plan will prevail.

Payment of Fees and Grace Period

1. The Group agrees to pay the current premiums billed by Company. Company reserves the right to change premiums on 60 days' written notice to the Group. Such change of premiums will become effective on the date specified in the notice and continued payment of premiums will constitute acceptance of the change.

2. Fees are due and payable beginning with the Effective Date of this Benefit Plan and on the same date each month thereafter. The Group is considered delinquent if fees are not paid as of the due date.

3. A grace period of 10 days shall be granted for the payment of premiums falling due after the first premium. During the grace period, this Benefit Plan shall continue in force subject to the right of Company to cancel in accordance with the cancellation provisions herein. If the Group does not make payment within 10 days of the due date, this Benefit Plan will be canceled as of the date premiums

were originally due. Company shall not be liable for any Benefits for services rendered following the date of cancellation.

4. Company will not be liable for issuing Claims decisions as set forth herein where Group premium payments are delinquent after the grace period as set forth in this Section, of this Benefit Plan. Once any such delinquent premiums are brought current by Group, the provisions related to claims and appeal decisions will apply to Members under the Benefit Plan.

5. All billing will be electronic. The Group agrees to pay premiums only through bank draft. Any payment of premiums made through means other than bank draft will be viewed by Company as a failure to pay premium.

6. Company may suspend claims payment if fees are not paid by the due date.

Benefits to Which Members are Entitled

1. The liability of Company is limited to the Benefits specified in this Benefit Plan.

2. Subject to the terms and provisions of this Benefit Plan, Benefits will be provided for Covered Services rendered or furnished by a Provider to a Member while he or she is covered under this Benefit Plan.

Notice of Member Eligibility - Employer's Personnel Data

1. The Group is solely responsible for furnishing the information that is required by Company for purposes of enrolling Members of the Group under this Benefit Plan, processing terminations, and effecting changes in family and membership status. Acceptance of payments for persons no longer eligible for coverage will not obligate Company to provide Benefits under this Benefit Plan.

2. All notification of membership or coverage changes must be on forms approved by Company and include all information required by Company to affect changes.

3. The Group warrants the accuracy of the information it transmits to Company and understands that Company will rely on this information. The Group agrees to supply or allow inspection of personnel records to verify eligibility as requested by Company.

4. The Group further agrees to indemnify Company for all expenses it incurs, if any, as a result of the Group's failure to transmit the information, failure to transmit it in the time period required by Company, and/or failure to transmit correct information.

5. The Group will provide the Company all electronic information necessary to complete enrollment of eligible Members, termination of coverage or any changes in family or membership status. The Group will complete all enrollment transactions electronically using *my*BlueGroup. The Group acknowledges that Company will not accept paper enrollment forms and that no enrollments or changes in membership will be affected by the submission of a paper form. Any

paper form submitted by the Group will be viewed by Company as failure to notify Company of enrollment change.

Termination of the Group

1. The Group may terminate this Benefit Plan by giving written notice to Company at least thirty (30) days in advance.

2. This Benefit Plan may be terminated in accordance with Article XV, Payment of Fees and Grace Period for the Group's nonpayment of the current fees when due or for the Group's failure to perform any obligation required by this Benefit Plan.

3. This Benefit Plan may be terminated effective immediately by Company in the event the Group commits an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact under the terms of this Benefit Plan.

4. This Benefit Plan may be terminated effective immediately by Company in the event the Group fails to comply with the employee participation percentage provision as outlined in the Employer Application and Agreement.

5. Company may terminate this Benefit Plan effective immediately when there is no longer a Member who lives, resides, or works in the service area of Company.

6. In the event Company decides to discontinue offering all group insurance coverage, Company may terminate this Benefit Plan by giving written notice to the Group, as well as the Commissioner of Insurance in each State in which an affected Member is known to reside, at least 180 days in advance of discontinuing the coverage.

Termination of a Member's Coverage

1. Member's coverage may be terminated for fraud or intentional misrepresentations of a material fact in connection with application for coverage or claim for Benefits. In any investigation of an alleged act of fraud or intentional misrepresentation of a material fact, Member must fully cooperate in any such investigation. Failure to fully cooperate in any such investigation or timely respond to inquiries in connection with any investigation will constitute an admission by the Member of the alleged fraud or intentional misrepresentation. The Member has the right to request an appeal of the termination.

2. In the event a Subscriber ceases to be in the employment of the Group, or in the event the Group notifies Company that coverage of a Subscriber is terminated pursuant to the Termination of the Group Section herein, the coverage of such Subscriber and all of his/her Dependents automatically, and without notice, terminates at the end of the period for which payment of fees has been made by the Group.

3. The coverage of the Subscriber's spouse will automatically terminate without notice at the end of the period for which fees have been paid at the time of the entry of a final decree of divorce or other legal termination of marriage.

4. The coverage of a child as a Member will terminate automatically without notice at the end of the month the child ceases to be an Eligible Dependent if fees have been paid through that month. Divorce of a Subscriber's child does not restore eligibility.

5. Upon the death of a Subscriber, the coverage of all of his/her surviving Dependents will terminate automatically and without notice the day following the date of the Subscriber’s death.

6. In the event the Group cancels this Benefit Plan or this Benefit Plan is terminated by Company for nonpayment of the appropriate payment when due or for the Group's failure to perform any obligation required by this Benefit Plan, such cancellation or termination alone will operate to terminate all rights of the Member to Benefits under the terms of this Benefit Plan as of the Effective Date of such cancellation or termination whether or not the Member is an Inpatient or Totally Disabled.

7. However, in the event of termination under the provisions of paragraphs 2, 3, or 4, within this Section, if the Subscriber or Dependent is a bed patient in a Hospital on the date of termination, Benefits will be provided for that patient to the end of that Hospital stay, but not to exceed 30 days from the date of termination. No Benefits will be provided for services, care, treatment or supplies which are furnished or rendered after the hospital stay or the 30 day period, whichever comes first.

8. Unless as otherwise specified in this Benefit Plan, no Benefits are available for services, care, treatment or supplies furnished or rendered to a Member after the date of cancellation or termination of the Member’s coverage.

9. When a member is reinstated or rehired within 30 days of the cancellation date, there is no lapse in coverage. The member will not be required to serve another probationary period.

10. When a member is reinstated or rehired more than 30 days following the cancellation date, and is required to be treated as a continuing employee under the Patient Protection and Affordable Care Act, the member will not be required to serve another probationary period upon enrollment by the Group.

Note: See the section below for Continuation Coverage.

Continuation Coverage

1. The Consolidated Omnibus Budget Reconciliation Act of 1985 (hereinafter referred to as COBRA) consists of healthcare continuation requirements that apply to all group health plans maintained by employers with (20) twenty or more employees on more than (50%) fifty percent of the typical business days during the previous calendar year. Group health plans that are not subject to COBRA are: 1) small-employer plans (employers with fewer than 20 employees during the preceding calendar year), 2) church plans (as defined by COBRA), and 3) governmental plans (as defined by COBRA).

a. When COBRA is applicable to the Benefit Plan, the Member, satisfying the requirements of a Qualified Beneficiary (See Definition Section), will have the option to elect COBRA Continuation Coverage under this Benefit Plan when he or she experiences a Qualifying Event. See the Qualifying Events listed below:

(1) If the Member is the employee, he or she has the right to choose COBRA Continuation Coverage in the event loss of coverage under this Benefit Plan is due to:

(a) a reduction in his or her hours of employment below the minimum required to participate in the Benefit Plan (Example: employee changes from full-time employment to part-time employment). The Member (Qualified Beneficiary) will be eligible to stay on the Benefit Plan for up to 18 months.

(b) voluntary or involuntary loss of his or her job, including retirement from the job. The Member (Qualified Beneficiary) will be eligible to stay on the Benefit Plan for up to 18 months.

SPECIAL NOTE: If an employee is terminated from employment due to a finding of “gross misconduct,” the loss of employment is not a Qualifying Event for COBRA Continuation Coverage. The Member will not be eligible to continue coverage under the Benefit Plan.

(c) A Member’s loss of coverage due to Family and Medical Leave Act is not a Qualifying Event for COBRA Continuation Coverage.

(2) If the Member is the legal spouse of the covered employee, he or she has the right to choose COBRA Continuation Coverage in the event loss of coverage is due to:

(a) the death of the covered employee. The legal spouse (Qualified Beneficiary) will be eligible to stay on the Benefit Plan for up to 36 months;

(b) termination of the covered employee’s employment (for reasons other than gross misconduct) or reduction in the covered employee’s hours of employment. The legal spouse (Qualified Beneficiary) is eligible to stay on the Benefit Plan for up to 18 months;

(c) divorce or legal separation from the covered employee. The legal spouse (Qualified Beneficiary) is eligible to stay on the Benefit Plan for up to 36 months;

(d) the covered employee becoming entitled to Medicare. Entitlement means enrollment in either Part A or Part B, not merely the covered employee becoming eligible to enroll in either Part A or Part B of Medicare. The legal spouse (Qualified Beneficiary) is eligible to stay on the Benefit Plan for up to 36 months.

(3) If the Member is the covered dependent child of the covered employee, he or she has the right to choose COBRA Continuation Coverage in the event loss of coverage is due to:

(a) the death of the covered employee. The covered dependent child is eligible to stay on the Benefit Plan for up to 36 months;

(b) termination of the covered employee's employment (for reasons other than gross misconduct) or reduction, in the covered employee's hours of employment. The covered dependent child is eligible to stay on the Benefit Plan for 18 months;

(c) the covered employee's divorce or legal separation from the covered dependent child's parent where the divorce or legal separation results in a loss of coverage for the covered dependent child. The covered dependent child (Qualified Beneficiary) is eligible to stay on the Benefit Plan for a period of 36 months;

(d) the covered employee becoming entitled to Medicare. Entitlement means enrollment in either Part A or Part B of Medicare. The covered dependent child (Qualified Beneficiary) is eligible to stay on the Benefit Plan for up to 36 months;

(e) the covered dependent child reaches an age (age 26 under this Benefit Plan) or condition which makes he or she no longer eligible to be covered under the Benefit Plan. The covered dependent child (Qualified Beneficiary) is eligible to stay on the Benefit Plan for a period of 36 months;

(f) a child born to a covered employee, or a child who is placed for adoption with the covered employee, during the covered employee's COBRA Continuation Coverage, will be eligible to become a Qualified Beneficiary. In accordance with the terms of the Benefit Plan and the requirements of the federal law, this child can be added to the COBRA Continuation Coverage upon proper notification to the Group and Company.

b. How to obtain COBRA Continuation Coverage.

(1) Under the Law, the Group (employer) or the Group's Plan Administrator, where applicable, has the responsibility to provide the Notice of COBRA Continuation Coverage Rights (Notice of COBRA), containing information about COBRA Continuation Coverage rights, to the employee and his or her spouse, within a 90 day period from the date the employee first becomes covered under the Benefit Plan.

(2) Under the law, the covered employee and his or her dependents have the responsibility to inform the Group (employer) or the Group's Plan Administrator, where applicable (See Important Information Section in the back of the Summary Plan Description), of a divorce, legal separation, a covered dependent child losing dependent status under this Benefit Plan, a determination of disability or a change of disability status has been made by the Social Security Administration, or of a second Qualifying Event, within 60 days of the later of: (1) the date of one of the aforementioned events or (2) the date on which coverage would otherwise end under this Benefit Plan because of the event, (3) the date that the Qualified Beneficiary receives notice (via the Summary Plan

Description or Notice of COBRA) of his or her obligation to furnish notice of the Qualifying Event and the procedures for furnishing that notice. In order to notify the Group (employer) or the Group's Plan Administrator, where applicable, of a possible Qualifying Event, the covered employee and his or her dependents should complete the COBRA Qualified Beneficiary Notice which contains the Member's and/or Qualified Beneficiaries' name, address, identification number, and a brief description of the event which may be a Qualifying Event for COBRA Continuation Coverage. The covered employee and his or her dependents should forward the COBRA Qualified Beneficiary Notice to the Group (employer) or where applicable the Group's Plan Administrator.

(3) Under the Law, the Group (employer) has the responsibility of notifying the Plan Administrator of the employee's termination of employment or reduction in hours, the employee's death, the employee's becoming entitled to Medicare, or the commencement of a proceeding in bankruptcy with respect to the employer. The Group (employer) must make this notification to the Plan Administrator within 30 days of the event as outlined above.

(4) When the Plan Administrator is notified that one of these events (listed in the paragraph above) has occurred, the Plan Administrator will, in turn, notify the Qualified Beneficiary that he or she has the right to choose COBRA Continuation Coverage. Notification to the Qualified Beneficiary will be in the form of a COBRA Continuation Coverage Election Notice (Election Notice). The Plan Administrator must send the Election Notice within 14 days of being notified of the event by the Group or the Qualified Beneficiary. Under the law, when the Group (employer) acts as the Plan Administrator, the Group must send the Election Notice within 44 days of the date on which the Qualified Beneficiary loses coverage under the Benefit Plan due to a Qualifying Event.

(5) A Qualified Beneficiary has 60 days from the date that he or she loses coverage because of one of the Qualifying Events outlined above, or from the date the Election Notice is sent to the Qualified Beneficiary, whichever is later, to inform the Plan Administrator that he or she wants COBRA Continuation Coverage.

(6) In the event the Qualified Beneficiary does not choose COBRA Continuation Coverage, his or her coverage under this Benefit Plan will end. A Qualified Beneficiary can only waive COBRA Continuation Coverage for himself or herself.

(7) If the Qualified Beneficiary chooses COBRA Continuation Coverage, he or she will have the same coverage under this Benefit Plan as he or she had on the day before the Qualifying Event.

(8) If the covered employee or covered dependent is entitled to Medicare at the time he or she has a qualifying event for continuation coverage under COBRA, the employee or dependent will have the option to continue coverage under the Benefit Plan. The COBRA Continuation Coverage rules will apply.

(9) If the Group (employer) or the Group's Plan Administrator, where applicable, receives any notice of a Qualifying Event from a Member or Qualified Beneficiary, who is not eligible to receive COBRA Continuation Coverage, the Group (employer) or the Plan Administrator, where applicable, will provide a Notice of Unavailability of Continuation Coverage to the individual explaining why he or she is not entitled to COBRA Continuation Coverage. The Group (employer) or the Group's Plan Administrator, where applicable, will provide the Notice of Unavailability of Continuation Coverage to the individual within 14 days after receiving notice of a qualifying event from the individual.

(10) Under the Law, a covered employee and his or her dependents, who are certified eligible for trade adjustment assistance pursuant to the Trade Act of 2002 and did not elect continuation coverage during the standard 60-day COBRA election period as a direct consequence of the trade adjustment assistance related loss of coverage, shall be provided a second 60-day COBRA enrollment period. This second enrollment period begins on the first day of the month in which the covered employee and his or her dependents are determined to be a trade act assistance eligible person, provided that such enrollment is made not later than six (6) months after the date of the trade assistance act related loss of coverage. Any coverage so elected will begin on the first day of the second election period, and not on the date on which coverage originally lapsed.

c. Payment for COBRA Continuation Coverage.

(1) The Qualified Beneficiary's payment for COBRA Continuation Coverage cannot exceed 102% of the applicable premium for similarly situation Members (An exception to this rule is if COBRA Continuation Coverage is extended due to disability, see below).

(2) Insured Plans (like this Benefit Plan) may charge total premium (employee's and employer's contribution) plus 2%.

(3) Premium payments are owed from the date of the Qualifying Event and must be paid within 45 days of the date the covered employee or covered Dependent elects COBRA Continuation Coverage.

(4) Premiums, after the first premiums, are due on a monthly basis. The Qualified Beneficiary is allowed a 30 day grace period every month for premium payment. The grace period begins on the first day of the coverage period.

d. Extending the Maximum Period

(1) Any Qualified Beneficiary determined to be disabled under Title II or Title XVI of the Social Security Act is entitled to a total of 29 months of COBRA Continuation Coverage, rather than the 18 months. To receive the disability extension, the Qualified Beneficiary must meet the following requirements:

(a) The Qualified Beneficiary must experience an 18 month Qualifying Event.

(b) The Social Security Administration must have determined that the individual (Qualified Beneficiary) was disabled (disability "onset" date) either before the Qualifying Event or within the first 60 days of the 18 month COBRA Continuation Coverage.

(c) The Group (employer) or the Group's Plan Administrator, where applicable, (see the Important Information Section of the Summary Plan Description) must have been provided with a copy of the Social Security determination of disability:

(i) before the end of the Qualified Beneficiary's initial 18 months of COBRA Continuation Coverage, and

(ii) within 60 days after the latest of:

(1) the date of the Social Security Administration disability determination;

(2) the date on which the Qualifying Event occurs;

(3) the date on which the Qualified Beneficiary loses coverage under the Plan as a result of the Qualifying Event; or

(4) the date on which the Qualified Beneficiary is informed of the obligation to provide disability notice.

(d) In the event the Qualified Beneficiary receives the 29 month disability extension, the Benefit Plan is permitted to request a payment amount that does not exceed 150 percent of the applicable premium for any period of COBRA Continuation Coverage covering a disabled Qualified Beneficiary, if the coverage would not be required to be made available in the absence of the disability extension.

(e) If the Qualified Beneficiary entitled to the disability extension has non-disabled family members who are entitled to COBRA Continuation Coverage, then non-disabled family members are also entitled to the 29 month disability extension.

(f) The Qualified Beneficiary must notify the Plan Administrator (See the Important Information Section of the Summary Plan Description) within 30 days of any final determination that the individual is no longer disabled.

(2) Multiple Qualifying Events

(a) A Multiple Qualifying Event is when a Qualifying Event (example: termination of employment) that gives rise to an 18 month maximum coverage period is followed by another Qualifying Event within the 18 month COBRA Continuation Coverage period. The second Qualifying Event (e.g. death of the covered employee) gives the Qualified Beneficiary a 36 month maximum coverage period. In this case the original 18 months period is expanded to 36 months from the original Qualifying Event date, but only for those individuals who were Qualified Beneficiaries under the Benefit Plan in connection with the

first Qualifying Event and who are still Qualified Beneficiaries at the time of the second Qualifying Event. NOTE: The Qualified Beneficiaries only receive the remaining balance of the 36 month period.

(b) Termination of the covered employee's employment following a reduction in hours event is considered a single 18 month Qualifying Event. These events together are not considered Multiple Qualifying Events.

e. Termination of COBRA Continuation Coverage.

(1) COBRA Continuation Coverage will be terminated when:

(a) the maximum available period of COBRA Continuation Coverage has been exhausted by the individual (example: the 18, 29, or 36 month period has run out);

(b) the Qualified Beneficiary fails to make a timely premium payment as specified in this Benefit Plan;

(c) the Qualified Beneficiary becomes covered by another group health plan after he or she has elected COBRA Continuation Coverage under this Benefit Plan. The only exception to this rule is the following:

(1) The Qualified Beneficiary may continue COBRA Continuation Coverage under this Benefit Plan if the new group health plan that the individual is enrolling in has an exclusion or limitation that applies to a Pre-existing Condition of the Qualified Beneficiary.

(2) An exception to (1) above is if the Qualified Beneficiary has 18 months of prior Creditable Coverage, with no break in coverage, prior to obtaining coverage under a new group health plan. In this instance, the Qualified Beneficiary's COBRA Continuation Coverage can be terminated.

(d) The Qualified Beneficiary becomes entitled to Medicare. Entitlement means enrollment in either Part A or Part B, not merely the individual becoming eligible to enroll in Part A or Part B of Medicare.

(e) The employer ceases to provide any group health plan to any employees.

(f) The Qualified Beneficiary ceases to be disabled according to the Social Security Administration after the Qualified Beneficiary's 11 month disability extension has begun.

(2) In the event of any termination of COBRA Continuation Coverage before the maximum available COBRA period has been exhausted, the Group (employer) or Group's Plan Administrator, where applicable, will provide a Notice of Termination of COBRA Coverage to the Qualified Beneficiary. This notice will explain the reason the coverage has been terminated, provide the date of the termination, and describe any right that the

Qualified Beneficiary may have to elect alternative group or individual coverage.

2. Continuation of Coverage (As Required by Section 83-9-51, As Amended, Mississippi Code of 1972)

   a. Subject to the provisions listed in this Section, the following individuals may be eligible to continue their coverage under this Benefit Plan.

      (1) A Subscriber whose coverage under this Benefit Plan ends may be eligible to elect continuation of coverage under this Benefit Plan for himself or herself and any eligible Dependents who were covered on the date the Subscriber's coverage ended.

      (2) A covered dependent spouse of a Subscriber may be eligible to elect continuation of coverage under this Benefit Plan for himself or herself and any covered dependent children for a period not to exceed twelve (12) months after: (a) the date of the death of the Subscriber; (b) the date of the dependent spouse's divorce from the Subscriber; (c) the date the Subscriber becomes entitled to Medicare.

      (3) A covered dependent child of the Subscriber may be eligible to elect continuation of coverage under this Benefit Plan for a period not to exceed twelve (12) months after the child ceases to be an eligible Dependent of the Subscriber as defined in this Benefit Plan.

   b. Continuation Coverage shall not be available for any person (Subscriber or Dependent) if:

      (1) the person was not continually covered under this Benefit Plan for three consecutive months immediately before the date his or her coverage ended; or

      (2) the person becomes eligible for other group coverage within 31 days after coverage under this Benefit Plan ends; or

      (3) the person could become eligible for other group coverage within 31 days after coverage under this Benefit Plan ends; or

      (4) the person's coverage under the existing Benefit Plan terminates due to fraud; or

      (5) the person's coverage under this Benefit Plan is terminated due to his or her failure to pay the required premium contribution; or

      (6) the person is eligible for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA).

      (7) the person becomes entitled to Medicare benefits.

   c. In order to receive continuation of coverage under this Benefit Plan, the person (Subscriber or Dependent) must adhere to the following provisions:

(1) The Subscriber must notify Company in writing of his or her election to continue coverage under this Benefit Plan (A form providing notification of the Subscriber's election to continue his or her coverage is available from Company); and pay any required contribution to Company no later than the date on which coverage under this Benefit Plan would otherwise end.

(2) In the event of the Subscriber's death, the Group shall notify Company of the date of the Subscriber's death. Within 14 days of receiving notification of the Subscriber's death, Company shall provide notice of the continuation privilege to the dependent spouse or the dependent child (or the legal representative of the dependent child). The dependent spouse or the dependent child has 30 days after receiving notice from Company to elect continuation coverage under this Benefit Plan (A form providing notification of the dependent spouse's or the dependent child's election to continue coverage is available from Company). The dependent spouse or the dependent child is required to pay any contribution to Company.

(3) In the event that a covered dependent child of the Subscriber ceases to be an eligible Dependent, the Group shall notify Company of the date the dependent child ceases to be an eligible Dependent. Within 14 days of receiving notification from the Group, Company shall provide notice of continuation privilege to the dependent child. The dependent child has 30 days after receiving notice from Company to elect continuation coverage under this Benefit Plan (A form providing notification of the dependent child's election to continue coverage is available from Company). The dependent child is required to pay any required contribution to Company no later than the date on which coverage under this Benefit Plan would otherwise end.

(4) In the event of the Subscriber's divorce from his or her dependent spouse, the Group shall notify Company of the date of the divorce. Within 14 days of receiving notification from the Group, Company shall provide notice of continuation privilege to the former dependent spouse. The former dependent spouse has 30 days after receiving notification from Company to elect continuation coverage under this Benefit Plan (A form providing notification of the former dependent spouse's election to continue coverage is available from Company). The dependent spouse is required to pay any required contribution to Company no later than the date on which coverage under this Benefit Plan would otherwise end.

(5) Special Note: Only the Subscriber may add newly eligible dependents in accordance with the rules set out in Article II, Schedule of Eligibility, Special Enrollment Periods, paragraph 3, 4 and/or paragraph 5.

d. Continuation of Coverage under this Benefit Plan shall terminate on the earliest of the following dates:

(1) Twelve calendar months from the date the person's (Subscriber) coverage under this Benefit Plan would have ended; or

(2) The date ending the period for which the person (Subscriber or Dependent) last paid any required premium contribution; if the person discontinues their contributions; or

(3) The date the person (Subscriber or Dependent) becomes or is eligible to become covered under group coverage which is similar to this Benefit Plan; or

(4) The date on which this Benefit Plan is terminated; or

(5) The date the surviving spouse or former spouse of the Subscriber remarries and becomes covered under another group health plan that does not exclude coverage for pre-existing conditions; or

(6) The date the person (Subscriber or Dependent) becomes entitled to Benefits under Medicare.

Network and Non-Network Providers

1. Network Provider

    a. Company has entered into payment agreements with Network Providers (Hospital, Physician or Allied Provider) to provide services to persons entitled to Network Benefits under Company's products, including Members under this Benefit Plan. Under these payment agreements, Blue Cross & Blue Shield of Mississippi does not always pay an amount to the Network Provider which corresponds to the Benefit amount. The payment made by Blue Cross & Blue Shield of Mississippi together with the Member's Network Deductible, Co-payment and/or Co-insurance may be greater than or less than Covered Charges. Any savings as a result of these payment agreements are utilized in the financing of this Benefit Plan.

    b. When a Member utilizes a Network Provider (Hospital, Physician or Allied Provider), the Network Provider is responsible for: (1) following the Company's Care Management requirements, (2) complying with Company's Medical and Prescription Drug Policy, (3) filing the Member's claim with the Company and (4) complying with the Company's Network Provider Agreements by not billing the Member for any charges that are determined not to be Medically Necessary or above the Allowable.

2. Non-Network Provider

    a. Network level Benefits will not be paid to a Non-Network Provider unless the Covered Services meet one of the following criteria:

        1. In unique situations when the Member requires the special services of a Non-Network Provider due to the fact that special services are not available by a Network Provider. The Member and his Network Provider must:

            a. Obtain the Company's pre-approval for a referral to a Non-Network Provider, and

            b. Provide documentation supporting the fact that the Admission to such Hospital or referral to such Provider is Medically Necessary.

2. In instances of further referrals (a third or more referral), the higher Benefit level will be paid as long as the Network Provider is involved in the referral and the referral is pre-approved by the Company.

3. Member is admitted as an Inpatient to a Hospital as a result of an Emergency.

4. Member receives Outpatient Services as a result of an Emergency.

b. Anytime the higher Benefit level is paid in the cases listed above, Co-payments and Co-insurance, if applicable, will accrue toward the Out-of-pocket amount. Once the Out-of-pocket amount is met, Benefits will be paid at 100% (where applicable) of the Allowable.

c. When a Member utilizes a Non-Network Provider (Hospital, Physician, or Allied Provider), the Member is solely responsible for (1) ensuring that the Non-Network Provider complies with the Care Management requirements set out in this Benefit Plan, (2) ensuring the Non-Network Provider complies with the Company's Medical Policy and (3) filing his or her claim electronically via the method established by the Company or ensuring the Non-Network Provider files the claim electronically via the method established by the Company. The Non-Network Provider's failure to comply with the Care Management requirements or to follow Medical Policy can result in a determination by Company that the services are non-covered or not Medically Necessary. Additionally, no Benefits are provided for certain Covered Services when the Member receives the services from a Non-Network Provider.

Claims Filing Requirements, Request for Services, and Time of Payment of Claims

1. Company will not be liable under this Benefit Plan unless, within one year from the date the Covered Service is rendered, a claim is filed with the Company in a form and manner that effectively provides notice to the Company that the Covered Service has been rendered. A claim will be considered incurred on the date the service or supply is actually rendered or provided to the Member.

2. The Provider or Member (where applicable) must file the appropriate claim form with the Company within one year after the services are rendered by the Provider. A claim for a Covered Service that has been provided by a Network Provider must be filed directly with the Company by such Provider within one year from the date the service is rendered.

3. Time of Payment of Claims

   a. Benefits for any loss caused under this Benefit Plan will be paid as follows:

      (1) Electronic Claims: After the Company receives the appropriate claim form, necessary medical information and any other information deemed essential by Company, Benefits will be paid within twenty-five (25) days after the receipt of a "Clean Claim."

      (2) Paper Claims: After the Company receives the appropriate claim form, necessary medical information and any other information deemed

essential by Company, Benefits will be paid within thirty-five (35) days after the receipt of a "Clean Claim."

b. In the event Benefits which are due are not paid within the time frames outlined above, Company will pay interest to Provider (where the claim is owed to the Provider) or the Member (where the claim is owed to the Member) equal to the rate of three percent (3%) per month accruing from the day after payment was due on the amount of Benefits.

c. In the event Company fails to pay Benefits as outlined above, the Provider or Member (where applicable) may bring an action to recover such Benefits and interest. If it is determined in such action that the Company acted in bad faith as evidenced by a repeated or deliberate pattern of failing to pay Benefits and/or Claims when due, the Provider or Member (where applicable) shall be entitled to recover damages in an amount up to three (3) times the amount of the Benefits that remain unpaid until the Claim is finally settled or adjudicated.

d. A "Clean Claim" is defined as a claim received by Company for adjudication and which requires no further information, adjustment or alteration by the Provider of services or the Member in order to be processed and paid by Company. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstances requiring special treatment that prevents timely payment from being made on the claim. Claims which must be researched for Coordination of Benefits or Subrogation issues will not be considered a Clean Claim. Upon request, Company shall provide to the Member or the Provider submitting a claim a written list of the information and documentation required for Company to deem a claim to be clean, and Company shall be bound by such list. Errors, such as system errors, attributable to the Company, do not change the clean claim status.

4. Non-Network Providers may file the claim electronically via the method established by the Company if the Member requests such. If they do not file the claim, it is the Member's responsibility to submit the claim electronically via the method established by the Company. It is the responsibility of the Member to assure that any claim for a Covered Service that has been provided by a Non-Network Provider is filed with the Company within one year from the date the service is rendered.

5. When a Member utilizes a Network Provider who provides certain Covered Services on a bundled claim basis, the Member's out-of-pocket expenses may be based upon the total of combined Covered Services instead of individually billed Covered Services. Covered Services will be provided at a percentage of the Allowable. The Member's responsibility will be based upon the Allowable for Covered Services previously agreed upon by Company and the Network Provider. One explanation of benefits for the combined Covered Services will be provided to the Member upon completion of the episode of care.

6. The Member may submit a claim electronically for payment directly to Company using the electronic method established by the Company. Member may contact Customer Service at 601-664-4590 if assistance is needed.

Individual Benefit Determination and Appeal Procedure

1. DEFINED TERMS (APPLICABLE ONLY TO THIS SECTION)

    a. Designation of Authorized Representative: A Member may designate an Authorized Representative to act on the Member's behalf. A designated Authorized Representative may be any individual who is not otherwise included under the same coverage as the Member. In an Emergency, a natural parent of a minor dependent Member and a provider of services for a Member may act on behalf of the Member without obtaining a formal designation. Any designation of an Authorized Representative must be submitted to the Company on a form that will be provided by the Company upon request of the Member. This Designation of Authorized Representative form must be signed by the Member whose claim is involved and submitted to CLAIMS REVIEW at the address specified on the form. Once an Authorized Representative has been formally designated by a Member, all communications pertaining to the claim at issue will be directed to the Authorized Representative. Anyone acting as an Authorized Representative for a Member must adhere to all procedures and requirements contained herein which are otherwise the responsibility and obligation of the Member.

    b. Pre-Service Claim: A claim that is submitted for a service(s) that has not yet been rendered to the Member and for which the terms of the Benefit Plan and/or Medical Policy require Prior Authorization as a condition of the receipt of benefits for the service(s).

    c. Urgent Care Claim: A Pre-Service Claim for which the initial Benefit determination time periods that otherwise apply to a Pre-Service Claim could seriously jeopardize the Member's life or health or ability to regain maximum function, or would, in the opinion of a Provider with knowledge of the Member's medical condition, subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Pre-Service Claim.

    d. Post-Service Claim: A claim that is submitted for medical services that have already been rendered to the Member. The Member will receive an electronic Explanation of Benefit reflecting the initial Benefit determination for claims that have been processed.

2. INITIAL BENEFIT DETERMINATION PROCEDURES

    a. Following the procedures outlined in the Care Management section of the Benefit Plan, the Member's Provider or the Member (when utilizing a Non-Network Provider) will request Prior Authorization of services where required.

    b. Once a claim or request for a Covered Service is received by the Company, the Member or the Provider may be advised if additional information is needed to finalize the claim processing. Company has the right to deny any claim where additional information (i.e. medical records, etc.) is not received within the timeframes provided for making an initial Benefit determination.

c. Timelines for Initial Benefit Determinations

(1) Certification of Emergency Admissions

(a) When the Member's Provider or the Member (only when utilizing a Non-Network Provider) submits a Certification of an Emergency Admission in accordance with the Care Management section of the Benefit Plan, Company will advise the Member's Provider of a decision, if the Company disagrees, as soon as possible taking into account the medical urgency, and in no case later than 72 hours after the Certification. Company will provide notice of approval to the Provider. If the request is denied, the Member and, if applicable, the Member's Provider will be notified of the determination within three days.

(2) Notice of Initial Benefit Decision for Pre-Service Claims

(a) When the Member or the Member's Provider submits a request for a Pre-Service Claim, a determination will be made and the Member and, if applicable, the Member's Provider, will be notified of the determination within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days from receipt of the Pre-Service Claim and all information necessary to make a determination. The Company has discretion (but is under no obligation) to extend the 15-day time period for reasons beyond the control of the Company.

(b) When the Member or the Member's Provider submits an Urgent Care Claim, a determination will be made and the Member and, if applicable, the Member's Provider, will be notified of the determination as expeditiously as the Member's condition requires, but no later than 72 hours from receipt of the request for services and all information necessary to make a determination.

(3) Notice of Initial Benefit Decision for Claims

(a) When a Post-Service Claim is submitted, a notification of a determination will be sent within a reasonable time period but not longer than 30 days from receipt of the claim. The Company has the discretion (but is under no obligation) to extend the 30-day time period for reasons beyond the control of the Company.

d. Appeal Procedures

(1) The Member or the Member's properly designated Authorized Representative will be entitled to request an appeal of an adverse Medical and/or Prescription Drug Benefit determination or retroactive cancellation of coverage determination. An appeal must be filed within 180 days from the receipt of the notice of an initial Benefit determination.

(2) A request for an appeal must be submitted in writing to CLAIMS REVIEW at the address specified in the initial benefit determination notification or the Explanation of Benefit form.

(3) The Member's request for an appeal should state why the decision is incorrect. The Member will have the opportunity to submit written comments, documents, or other information in support of the appeal. Once a request for an appeal is received by the Company, the Member or the Provider may be advised if additional information is needed to finalize the decision. Company has the right to deny any appeal where additional information (medical records, etc.) is not received within the timeframes provided for making a decision on an appeal.

(4) Upon request and free of charge, the Member will have access to and be provided copies of relevant documents. The review of the initial Benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

(5) The appeal will be conducted by a representative of the Company who is neither the individual who made the initial Benefit determination nor the subordinate of such individual. If the appeal involves a medical judgment question, the Company will consult with an appropriately qualified healthcare practitioner with training and experience in the field of medicine involved in the medical judgment.

(6) A final decision on an appeal will be made within the time periods specified below:

(a) Appeal of an Emergency Admission, Urgent Care Claim or Expedited Review of Prescription Drug Benefit Determination

In the event the Certification of the Emergency Admission or request for an Urgent Care Claim or Benefits for certain Prescription Drugs are denied, the Member's Provider may request an expedited review of the denial. Exigent circumstances must exist for there to be an expedited Prescription Drug review. This request should be made by telephone, facsimile, or similarly rapid communication method. Utilizing the same communication method, Company will notify the Member's Provider as soon as possible, but in no less than 72 hours for an Emergency Admission or an Urgent Care Claim after the receipt of the expedited review of the Company's approval or continued denial of the services or 24 hours after receipt of the Prescription Drug expedited review request. The Member will be notified of the continued denial of services. Company will defer to Provider's determination of whether a Claim is subject to expedited review. If expedited review is granted, any review will be conducted within seventy-two (72) hours of the request.

(b) Appeal of a Pre-Service Claim

When a Member requests an appeal of a Pre-Service Claim, the Member will be notified of the determination within a reasonable period of time taking into account the medical circumstances, but no later than 30 days from the date the request is received.

(c) Appeal of Claims or Prescription Drug Benefit Determination

When the Member requests an appeal of a claim denial, the Member will be notified of the determination or status within a reasonable period of time but no later than 60 days from the date the request is received.

(7) If the Company does not respond to an appeal or request additional time to respond within the time periods stated above, all administrative remedies will be deemed exhausted.

e. Contents of notification for adverse decisions for Emergency Admission, Urgent Care Claims, Pre-Service Claims, claims and appeals.

(1) The notice of initial Benefit determination for adverse decisions Emergency Admissions, Urgent Care Claims, Pre-Service Claims, claims and appeals will contain the following information:

(a) the specific reason or reasons for the adverse determination;

(b) a reference to the Company's claims review procedures and a statement of the Member's rights pursuant to Section 502(a) of ERISA, if the Member's Benefit Plan is subject to ERISA;

(c) state whether the denial is based on a medical necessity exclusion or limitation and advise that the Member will be provided with an explanation of the determination free of charge upon request.

(2) In addition, the notification of an adverse decision for Emergency Admissions, Urgent Care Claims, Pre-Service Claims, of services and appeals will disclose whether any internal rule, guideline or protocol was relied on in making the adverse determination and provide that a copy of such information will be made available free of charge upon request. It will reference the specific plan provision on which the Benefit determination is based.

(3) Notifications for Pre-Service Claims will also indicate whether additional material or information is needed to perfect the request for services. Notifications for appeals will provide that the Member is entitled to receive upon request and free of charge reasonable access to and copies of all documents, records and other information relevant to the claim for Benefits.

(4) The notice of initial Benefit determination for adverse claims will also indicate whether additional material or information is needed to perfect the claim.

f. External Review

(1) In the case of an adverse Medical or Prescription Drug benefit determination based on Medical Necessity, appropriateness of care, healthcare setting, level of care, effectiveness of care, or whether Company is complying with surprise billing and cost-sharing protections under the No Surprises Act, you have the right to have that determination reviewed by an independent healthcare professional who has no association with Company. All internal appeals/reviews as provided for in

this Benefit Plan must be exhausted prior to the submission of a request for external review. An external review must be initiated within 4 months of the receipt of notice of an Adverse Benefit Determination. Requests for external review must be submitted through the Office of the Insurance Commissioner, Mississippi Insurance Department, Attn: Life and Health Actuarial Division, P.O. Box 79, Jackson, MS 39205, Phone: (601) 359-3569. A decision will be rendered within 45 days of receiving your request. If the Member has a medical condition that would seriously jeopardize their life or health or would jeopardize their ability to regain maximum function if treatment is delayed, the Member may be entitled to request an expedited external review of the adverse benefit determination. A determination will be rendered on an expedited external review as expeditiously as possible.

(2) If the adverse benefit determination is based on a determination that the service or treatment is experimental or investigational, the Member may also be entitled to file a request for external review of our denial. Any such external review must be initiated within 4 months of the receipt of notice of an Adverse Benefit Determination. Requests for external review of an adverse Medical benefit determination must be submitted through the Office of the Insurance Commissioner.

(3) If the Member believes the adverse Medical benefit determination is due to Company's failure to comply with the surprise billing and cost-sharing protections under the No Surprises Act, the Member may be entitled to file a request for External Review. In these instances, the Member must follow the External Review requirements and procedures set forth in paragraph (1) above.

(4) To initiate an External Review, Member will be required to authorize the release of any medical records of the Member that may be required to be reviewed for the purposes of reaching a decision on the external review.

g. Non-Formulary Prescription Drug Exception Request.

(1) In the case of an adverse Prescription Drug benefit determination based on the clinical appropriateness of certain non-formulary Prescription Drugs, you have the right request an Nonformulary Prescription Drug Exception. The Non-Formulary Prescription Drug Exception request must be received within 90 days of the date of the adverse Prescription Drug benefit determination.

(2) If the Non-Formulary Prescription Drug Exception Request is determined to not be clinically appropriate, you have the right to have the clinical appropriateness determination reviewed by an independent reviewer. All internal appeals/reviews as provided for in this Benefit Plan must be exhausted prior to the submission of a request for external review. An external review must be initiated within 4 months of the receipt of notice of an Adverse Benefit Determination. Requests for external review must be submitted through Company. A decision will be rendered within 72 hours of receiving your request. If the Member has a medical condition that would seriously jeopardize their life or health or would jeopardize their ability to regain maximum function if treatment is delayed, the Member may be entitled to request an expedited external review of the

adverse benefit determination. A determination will be rendered on an expedited external review within 24 hours of receiving your request. Requests for external review of an adverse Prescription Drug benefit determination must be submitted through Company.

(3) In the event a request for Benefits for certain non-formulary Prescription drugs is denied, the Member will be notified of the determination within a reasonable period of time but no later than 72 hours from the date the request is received.

Legal Action

The Member may not bring a lawsuit to recover Benefits under this Benefit Plan until the Member has exhausted the administrative process described in the section entitled Individual Benefit Determination and Appeal Procedure. No action may be brought at all unless brought no later than 3 years following a final decision on the claim for Benefits by Company. The 3-year statute of limitations on suits for all Benefits shall apply in any forum where the Member may initiate such suit.

Release of Information

1. Each Member receiving care under this Benefit Plan authorizes and directs any Provider to furnish to Company, at any time upon its request, all information, records, copies of records or testimony relating to attendance, diagnosis, examination, or treatment. Such authorization and compliance therewith by each Provider affected will be a condition precedent to rights to Benefits to each Member hereunder, and no Benefits will be provided in any case where such authorization is not given full effect. Company will utilize the information described in this paragraph for internal administration of this Benefit Plan, medical analysis, coordination of benefit provisions with other plans, subrogation of claims, or in the reviewing of a disputed claim. Additionally, Company will hold such information, records, or copies of records, as confidential except where in its discretion the same should be disclosed.

2. Company, as part of Care Management activities may disclose health information or information about a Member's utilization to a treating physician or dispensing pharmacy.

Payment of Benefits

Non-Network Benefits and Direct Payment to Member

1. All Benefits payable by Company under this Benefit Plan and any amendment hereto are personal to the Member and are not assignable in whole or in part by the Member, but Company has the right to make payment to a Hospital, Physician, or other Provider (instead of to the Member) for Covered Services which they provide while: 1) there is in effect between Company and any such Hospital, Physician, or other Provider an agreement calling for Company to make payment directly to them; or 2) the Member provides written direction that Benefits for Covered Services are to be paid directly to a Non-Network Provider.

In the absence of such an agreement for direct payment or Member's written direction of payment to a Non-Network Provider, Company will pay to the Member and only the Member those Benefits called for herein and Company will not recognize a Member's attempted assignment to, or direction to pay, another.

2. Hospitals, Physicians, and other Providers which have agreed with Company or another Blue Cross and Blue Shield Plan for such direct payment are, by reason of such agreements, "Network Providers". Those Hospitals, Physicians, and other Providers which do not have such agreements for direct payment are "Non-Network Providers".

3. If Company has offered a Hospital, Physician or other Provider an agreement for direct payment by Company, but there is no such agreement in effect when Covered Services are rendered to a Member by such Hospital, Physician or other Provider, Company will not recognize a Member's attempted assignment to, or direction to pay, such Hospital, Physician or other Provider, but Company will pay to the Member and only the Member those Benefits called for in this Benefit Plan and any amendment thereto. Only upon the Member's written direction that Benefits for Covered Services be paid directly to a Non-Network Provider will the direction of payment be made to such Non-Network Provider.

4. Company reserves the right to select the Hospitals, Physicians, and other Providers with which it will make agreements for direct payment by Company for Covered Services they render Members, based on criteria established by the Company.

5. When a Provider without an agreement with Company for direct payment by Company, that is, a Non-Network Provider renders Covered Services to a Member, Company, in its discretion, may reduce the level of Benefits payable by the Company under this Benefit Plan and any amendment hereto, for such services, to fifty percent (50%) of the Allowable. When Network Provider access for Covered Services is available in a Network Service Area and the Member receives Covered Services from a Non-Network Provider, Covered Services may be considered non-covered. This provision has no effect on the other provisions of this Benefit Plan which indicate that Benefits are not provided for certain services rendered by a Non-Network Provider (e.g. Immunizations, mammography).

6. The Deductible Amount will remain the same as specified herein and will not be increased or reduced by this provision.

Surprise Medical Bills

The No Surprises Act ("NSA") is a federal law that provides the Member with protections against certain surprise bills and prohibits Providers from balance billing the Member for services under certain circumstances. Generally, these protections apply when the Member (1) receives emergency care or (2) receives care from a Non-Network Provider at a Network Hospital or Network Ambulatory Surgery Facility. In these limited circumstances, Company must apply the NSA protections which may impact coverage, cost-sharing and other consumer protections set forth in this Benefit Plan. For specific information on how the NSA may impact a specific claim for services under this Benefit Plan or the rights and protections the Member has under the NSA, please visit the Surprise Billing and Balance Billing Protections

information located at www.bcbsms.com/im-a-member or contact Company using the contact information provided in this Benefit Plan.

Member/Provider Relationship

1. The choice of a Provider is solely the Member's.

2. Company does not render Covered Services but only makes payment for Covered Services received by Members. Company is not liable for any act or omission of any Provider. Company has no responsibility for a Provider's failure or refusal to render Covered Services to a Member.

3. The use or non-use of an adjective such as Network or Non-Network in referring to any Provider is not a statement as to the ability of the Provider.

Applicable Law and Venue

This Benefit Plan will be governed and construed in accordance with the laws and regulations of the State of Mississippi except when preempted by federal law. Venue for any action arising out of this Benefit Plan shall be brought in the State or Federal courts having jurisdiction in Rankin County, Mississippi.

Coordination of Benefits (Group and Individual Coverage)

1. Applicability:

    a. This Coordination of Benefits ("COB") section applies to This Plan when the Subscriber or the Subscriber's covered Dependent has healthcare coverage under more than one plan. "Plan" and "This Plan" are defined below.

    b. The Order of Benefit Determination Rules determine which Plan will pay as the Primary Plan. The Plan that pays first is the Primary Plan. The Primary Plan pays first without regard to the possibility that another Plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

2. Definitions: (Applicable only to this section)

    a. "Plan" means any health plan which provides services, supplies, or equipment for Hospital, surgical, medical, or dental care or treatment, including but not limited to, coverage under group or individual insurance policies, non-profit health service plans, health maintenance organizations, subscriber contracts, self-insured group plans, pre-payment plans, automobile or homeowners medical pay plans, workers' compensation coverages, and Medicare, as permitted by federal law. This does not include, Medicaid, Hospital daily indemnity plans, specified diseases only policies, or limited occurrence policies which provide only for intensive care or coronary care in the Hospital.

Each Plan or other arrangement for coverage is a separate plan. If an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

b. "This Plan" means the part of this Group's Benefit Plan that provides Benefits for healthcare expenses.

c. "Primary Plan"/"Secondary Plan," The Order of Benefit Determination Rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has healthcare coverage under more than one Plan.

When This Plan is primary, it determines payment for its Benefits before those of any other Plan without considering the other Plan's benefits.

When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the Benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

3. Order of Benefit Determination Rules:

a. When a Subscriber or Dependent is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

(1) This Plan is a Secondary Plan if the other Plan contains no provision for Coordination of Benefits.

(2) If both Plans contain Coordination of Benefit provisions, this Plan is a Secondary Plan which has Benefits determined after those of the other Plan, unless

(a) the other Plan has rules coordinating its Benefits with those of This Plan; and,

(b) both those rules and This Plan's rules, in subparagraph b. below, require that This Plan's Benefits be determined before those of the other Plan.

b. Each Plan determines its order of Benefit payments using the first of the following rules that apply:

(1) Non-dependent/Dependent: The Benefits of the Plan which covers the person as an employee, member, policyholder, subscriber or retired employee (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

(a) Secondary to the Plan covering the person as a dependent, and

(b) Primary to the Plan covering the person as other than a dependent (e.g., a retired employee),

then the Benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a Dependent.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan, the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

1. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan.

2. If both parents have the same birthday, the Plan which has covered the parent the longest is the Primary Plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

1. If a court decree states one of the parents is responsible for the dependent child's healthcare expenses or healthcare coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

2. If the court decree states both parents are responsible for the dependent child's healthcare expenses or healthcare coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

3. If a court decree states that the parents have joint custody without specifying that one parent is responsible for the healthcare expenses or healthcare coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits;

4. If there is no court decree allocating responsibility for the dependent child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:

a. The Plan covering the custodial parent;

b. The Plan covering the spouse of the custodial parent;

c. The Plan covering the non-custodial parent; and then

d. The Plan covering the spouse of the non-custodial parent.

(3) Joint Custody: If the specific terms of a court decree state that the parents will share joint custody without stating that one of the parents is responsible for the healthcare expenses of the child, the Plans covering the child will follow the order of Benefit determination rules outlined in Paragraph 3.b.(2).

(4) Active/Inactive Employee: The Benefits of a Plan which covers a person as an employee who is neither laid off nor retired are determined before those of a Plan which covers that person as a laid off or retired employee. The same would hold true if a person is a dependent of a person covered as an active employee and a retired or laid off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of Benefits, this rule (5) is ignored.

(5) Continuation coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the Benefits of the Plan covering the person as an employee, member, subscriber or retired employee (or as that person's dependent) is the Primary Plan and the Benefits under the continuation coverage is the Secondary Plan.

If the other plan does not have the rule described above, and as a result, the Plans do not agree on the order of Benefits, this rule is ignored.

(6) Longer/Shorter Length of Coverage: If none of the above rules determine the order of Benefits, the Benefits of the Plan which covered an employee, member, subscriber or retired employee longer are determined before those of the Plan which covered that person for the shorter time. SPECIAL NOTE: For the purposes of this sub-paragraph (6) only, a change in the entity that pays, provides, or administers the plans; or a change from one type of benefit plan to another type of benefit plan; or a change in the level or scope of a plan's benefits shall not constitute the start of a new plan; therefore, the covered employee, member or Subscriber shall not be able to claim a shorter coverage period under this sub-paragraph.

4. Effect on the Benefits of This Plan:

This Section 4 applies when, in accordance with Section 3, this Plan is a Secondary Plan as to one or more other plans. In that event This Plan will provide Benefits based on the difference between the amount the other Plan or Plans paid and the amount established by Blue Cross & Blue Shield of Mississippi as the maximum amount for Provider Services covered under the terms of this Plan. Additionally, in the event the amount that the Primary Plan pays exceeds the amount established by Blue Cross & Blue Shield of Mississippi as the maximum amount for Provider services covered under the terms of this Plan, this Plan will incur no secondary liability. Note: In no event will the amount this Plan provides as Secondary Plan exceed the amount it would have provided as the Primary Plan.

5. Right to Receive and Release Needed Information:

Certain facts about healthcare coverage and services are needed to apply these COB rules and determine Benefits payable under This Plan and other Plans.

Blue Cross & Blue Shield of Mississippi, may obtain the facts it needs from, or give them to, other organizations or persons for the purpose of applying these rules and determining Benefits payable under This Plan and other Plans covering the person claiming benefits. Blue Cross & Blue Shield of Mississippi is not required to tell or get the consent of any person to do this. Each person claiming Benefits under This Plan must give Blue Cross & Blue Shield of Mississippi any facts it needs to apply those rules and determine Benefits payable. Blue Cross & Blue Shield of Mississippi has the right to deny all claims unless and until the Member provides it with the requested facts and any of the insurance information needed to apply the COB Rules.

6. Facility of Payment:

   A payment made under another Plan may include an amount which should have been paid under This Plan. Blue Cross & Blue Shield of Mississippi may pay that amount to the organization which made that payment. That amount will then be treated as though it were a Benefit paid under This Plan. Blue Cross & Blue Shield of Mississippi will not have to pay that amount again. The term "payment made" includes providing Benefits in the form of services, in which case the payment made will be deemed to be the reasonable cash value of any Benefits provided in the form of services.

7. Right of Recovery:

   If the amount of the payments made by Blue Cross & Blue Shield of Mississippi is more than it should have paid under this COB provision, it may recover the excess. It may get such recovery or payment from one or more of:

   a. The persons it has paid or for whom it has paid;

   b. Insurance companies; or

   c. Other organizations.

   The "amount of the payments made" includes the reasonable cash value of any Benefits provided in the form of services.

8. Medical Payments Coverage

   a. Where any medical payment sums are applicable to a Member under any coverage, including but not limited to automobile and premises policies, the limits of any such applicable coverage must be applied to related claims before any benefits will be provided under This Plan.

   b. Member will take such action, furnish such information and assistance and execute such papers as Company may require in order to document that the applicable medical payment monies have been fully utilized.

   c. In the event that applicable medical payment monies have not been fully utilized for related claims prior to the time This Plan begins providing benefits for related claims, Company may determine or deem certain claims to be the responsibility of medical payments coverage and may recover directly from the provider of services any payments previously made in order to facilitate full use of the applicable medical payment monies to related claims. Benefits

under This Plan will be denied for these same services and shall be the financial responsibility of the Member where any related claims for which benefits have been provided are determined or deemed to be the responsibility of medical payments coverage.

Working Aged Provisions

1. For employers having 20 or more active employees, federal law and regulations require that, each active Employee, age 65 or older, and each active Employee's spouse age 65 or older, may elect to have coverage under this Benefit Plan or under Medicare.

    a. Where such Employee or such spouse elects coverage under this Benefit Plan, this Benefit Plan will be the primary payor of Benefits with the Medicare program the secondary payor.

    b. This Benefit Plan will not provide Benefits to supplement Medicare payments for an active Employee age 65 or older or for a spouse age 65 or older of an active Employee where such Employee or such spouse elects to have the Medicare program as the primary payor.

2. Under federal law if an active Employee under age 65 or an active Employee's Dependent under age 65 is covered under a group Benefit Plan of an employer with 100 or more employees and also has coverage under the Medicare program by reason of social security disability, the group Benefit Plan is the primary payor and Medicare is the secondary payor.

3. For persons eligible for Medicare based on end-stage renal disease, the Medicare Program will be the secondary payor and this Benefit Plan will be the primary payor during the first 30 months of end-stage renal disease-based eligibility. At the end of the 30 month coordination period, Medicare will be the primary payor.

4. When this Benefit Plan is the primary payor, it will provide regular Benefits toward Covered Services. When this Benefit Plan is the secondary payor, it will provide Benefits not to exceed the difference between actual charges for services and the amount paid by Medicare (or the difference between the Medicare approved charge and the amount Medicare paid if assignment is accepted by the Physician).

5. In order for Company to identify dual coverage situations and to determine whether primary or secondary payment should be made for a Member’s claim, the Group agrees to provide all necessary information requested by Company. The Group, as well as its employees and covered Dependents, is responsible for the accuracy of the information provided to Company. Company will not be responsible for any inaccurate information provided by the Group or the employees and Dependents covered under this Benefit Plan.

Notice and Change of Address

Any notice required by the Member or the Group under this Benefit Plan must be submitted electronically. Notice given to the Member will be sent electronically to the Member's email address stated in the Application, or notice given to the Group will be sent electronically to the Group's email address as the same appears on the records of Company. Notice given to Company can be sent electronically or by mail to the Company's address stated in the Application.

The Member or the Group must ensure that the current physical and email addresses are provided to Company. In the event the Member's physical or email address changes, he or she must immediately provide notification of the new address to Company, or in the event, the Group's physical or email address changes, the Group must immediately provide notification of the new address to Company. Company, in its discretion, may utilize a third party vendor to update and verify the Member's or Group's physical and email addresses.

Subrogation-Work Related

1. In order to provide Benefits and/or where Benefits have already been provided for Covered Services under the terms of the Benefit Plan for any injury, illness or condition for which a claim has been or will be pursued under any worker's compensation laws, which would otherwise be excluded under the Benefit Plan, an Accident Questionnaire must be completed and submitted by the Member or one authorized by law to act on the Member's behalf. Payments of any Benefits with notice to the worker's compensation carrier will allow Company to be subrogated to and succeed to the rights of the Member for recovery against the employer or carrier. Nothing contained in this Section will be deemed to change, modify or vary the terms of the Coordination of Benefits section of the Benefit Plan.

2. Pursuant to the above provision, the Member agrees to provide Company with prior notice of and opportunity to participate in any settlement of Member's claim and further agrees that, as a part of any worker's compensation settlement, Company will be reimbursed in accordance with applicable laws for Benefits paid under the Plan.

3. Member will take such action, furnish such information and assistance and execute such papers as Company may require to facilitate enforcement of its rights and will take no action prejudicing the rights and interest of Company under the Benefit Plan.

4. The Member must immediately notify the Company or any injury, illness or condition for which a claim has been or will be pursued under any applicable worker's compensation laws.

Subrogation-Third Party

1. In order to provide Benefits and/or where Benefits have already been provided for Covered Services under the terms of the Benefit Plan for injuries growing out of any act or omission of another party for which a claim or recovery is or will be

pursued, which would otherwise be excluded under the Benefit Plan, an Accident Questionnaire must be completed and submitted by the Member or one authorized by law to act on the Member's behalf within thirty (30) days of receipt of same.

2. Payments of any Benefits will allow Company to be subrogated to and succeed to the rights of the Member for recovery against any person, organization or carrier in accordance with applicable laws. In the event the Member is a minor, Chancery Court approval must be obtained prior to the payment of any Benefits. Any subrogation claim shall be a first priority lien on the full or partial proceeds of any settlement, judgment or other payment recovered by or on behalf of the Member to the extent allowed by law. Also, to the extent permitted by law, this lien applies whether or not the covered person has been fully compensated for all of his or her losses. All attorney fees, costs and other expenses that the Member incurs in exercising any right of recovery will be the Member's responsibility. Amounts that Company paid for which a third party is responsible will not be reduced by the amount of the Member's attorney fees, costs or other expenses. To the extent allowed by law, Company's rights under this provision cannot be defeated by allocating the proceeds, in whole or in part, to non-medical damages. Member shall hold any recovery in trust on behalf of Company to reimburse the Plan promptly for Benefits paid. Nothing contained in this Section will be deemed to change, modify or vary the terms of the Coordination of Benefits section of this Plan.

3. Pursuant to the above provision, the Member agrees to provide Company with prior notice of and opportunity to participate in any settlement of Member's claim and further agrees that, as a part of any settlement, Company will be reimbursed in accordance with applicable laws for Benefits paid under this Plan.

4. Member will take such action, furnish such information and assistance and execute such papers as Company may require to facilitate enforcement of its rights and will take no action prejudicing the rights and interest of the Company under this Plan.

5. The Member must immediately notify the Company of any claim or recovery which will be pursued as a result of an act or omission of another party.

6. The right to recover by subrogation shall apply to settlements or recoveries of deceased persons, disabled Subscribers, minor dependents of a Subscriber, or disabled Eligible Dependents.

Contractual Right to Reimbursement

1. In order to provide Benefits and/or where Benefits have already been provided for Covered Services under the terms of the Benefit Plan for injuries growing out of any act or omission of another party for which a claim or recovery is or will be pursued, which would otherwise be excluded under the Benefit Plan, an Accident Questionnaire must be completed and submitted by the Member or one authorized by law to act on the Member's behalf within thirty (30) days of receipt of same.

2. In the event a Member receives full or partial proceeds from any other source for Covered Services for an Illness or Injury, Company has a contractual right of reimbursement to the extent Benefits were paid under this Contract for the same Illness or Injury. To the extent permitted by law, this contractual right shall be a

first priority lien on the full or partial proceeds of any settlement, judgment or other payment recovered by or on behalf of the Member. To the extent allowed by law, this lien applies whether or not the covered person has been fully compensated for all of his or her losses. All attorney fees, costs and other expenses that the Member incurs in exercising any right of recovery will be the Member's responsibility. Amounts that Company paid for which a third party is responsible will not be reduced by the amount of the Member's attorney fees, costs or other expenses. Member shall hold any recovery in trust on behalf of Company to reimburse the Plan promptly for Benefits paid.

3. Such proceeds may include any settlement; judgment; payments made under group auto insurance; individual or group no-fault auto insurance; another person's uninsured, underinsured or medical payment insurance; or proceeds otherwise paid by a third party. This contractual right to reimbursement is in addition to, and separate from, the subrogation right. To the extent allowed by law, Company's rights shall not be defeated by allocating the proceeds in whole or in part, to non-medical damages.

4. The right to recover by reimbursement shall apply to settlements or recoveries of deceased persons, disabled Subscribers, minor dependents of a Subscriber, or disabled Eligible Dependents. In the event the Member is a minor, Chancery Court Approval must be attained prior to the payment of any benefits.

5. The Member agrees to fully cooperate and assist in any way necessary to recover such payments, including but not limited to notifying Company of a claim or lawsuit filed on his or her behalf or on behalf of any Eligible Dependents for an Injury or Illness. The Member or an authorized representative shall contact Company prior to settling any claim or lawsuit to obtain an updated itemization of its subrogation claim or reimbursement amount due. To the extent allowed by law, upon receiving any proceeds subject to this Section, the Member or an authorized representative must hold in trust proceeds in an amount equal to Benefits paid by Company in connection with injuries growing out of any act or omission of another party until such time as the proceeds can be transferred to the Company. Such party holding the funds that rightfully belong to the Company shall not interrupt or prejudice the Company's recovery under this Section.

Right of Recovery

Whenever any payment for Covered Services has been made by Company in an amount that exceeds the maximum Benefits available for such services under this Benefit Plan, or whenever payment has been made in error by Company for non-covered services, Company will have the right to recover such payment from the Member or, if applicable, the Provider. As an alternative, Company reserves the right to deduct from any pending claim for payment any amounts the Member or Provider owes Company.

Coverage in a Veterans Administration or Military Hospital (As Required by COBRA)

In any case in which a veteran is furnished care or services by the Veterans Administration for a non-service connected disability, the United States will have the right to recover or collect the reasonable cost of such care or services from Company to the extent the veteran would be eligible for Benefits for such care or services from

Company if the care or services has been furnished by a Provider other than the Veterans Administration. The amount that the United States may recover will be reduced by the appropriate Deductible Amount and Co-payment amount. The intent of this provision is to comply with PL 99-272, section 19013.

The United States will have the right to collect from Company the reasonable cost of Inpatient Hospital care incurred by the United States on behalf of a military retiree or a military Dependent through a facility of the United States military to the extent that such retiree or Dependent would be eligible to receive reimbursement or indemnification from Company if the retiree or Dependent were to incur such cost on his or her own behalf. The amount that the United States may recover will be reduced by the appropriate Deductible Amount and Co-payment amount. The intent of this provision is to comply with PL 99-272, section 2001.

Independent Corporation

The Group on behalf of itself and its participants hereby expressly acknowledges its understanding that this agreement constitutes a contract solely between the Group and Blue Cross & Blue Shield of Mississippi, that Blue Cross & Blue Shield of Mississippi is an independent corporation operating under a license with the Blue Cross and Blue Shield Association (hereinafter referred to as "the Association"), an association of independent Blue Cross & Blue Shield Plans, the Association permitting Blue Cross & Blue Shield of Mississippi to use the Blue Cross and Blue Shield Service Mark in the State of Mississippi, and that Blue Cross & Blue Shield of Mississippi is not contracting as the agent of the Association. Group further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than Blue Cross & Blue Shield of Mississippi and that no person, entity, or organization other than Blue Cross & Blue Shield of Mississippi shall be held accountable or liable to the Group for any of Blue Cross & Blue Shield of Mississippi's obligations to the Group created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross & Blue Shield of Mississippi other than those obligations created under other provisions of this agreement.

Family and Medical Leave Act of 1993

The Member may be eligible for certain rights under the Family and Medical Leave Act of 1993.

Out-of-Area Services

Company has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements”. These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association (“Association”). Whenever the Member accesses healthcare services outside the geographic area the Company serves, the claims for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When the Member receives care outside of Company's service area, the Member will received it from one of two kinds of providers. Most providers ("Network Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some providers ("Non-Network Providers") don't contract with the Host Blue. Company's payment practices in both instances are described below.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits (except when paid as medical claims/benefits), and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by the Company to provide the specific service or services.

1. BlueCard® Program

   Under the BlueCard® Program, when the Member receives Covered Services within the geographic area served by a Host Blue, Company will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Network Providers.

   When the Member receives Covered Services outside Company's service area and the claim is processed through the BlueCard Program, the amount the Member pays for Covered Services is calculated based on the lower of:

   a. The billed covered charges for the Member's Covered Services; or

   b. The negotiated price that the Host Blue makes available to Company.

   Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Member's healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with the Member's healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

   Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price Company has used for the Member's claim because they will not be applied after a claim has already been paid.

2. Special Cases: Value-Based Programs

   a. If the Member receives Covered Services under a Value-Based Program inside a Host Blue's service area, the Member will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Company through average pricing or actual pricing.

   b. Definitions: (Applicable only to this Section)

(1) “Care Coordination” means organized, information-driven patient care activities intended to facilitate the appropriate response to a Member’s healthcare needs across continuum of care.

(2) “Care Coordinator Fees” means a fixed amount paid by a Blue Cross and/or Blue Shield Licensees to Providers periodically for Care Coordination under a Value-Based Program.

(3) “Provider Incentive” means an additional amount of compensation paid to a Provider by a Blue Cross and/or Blue Shield Licensees, based on the Provider’s compliance with agreed-upon procedural and/or outcome measures for a particular group of covered persons.

(4) “Value-Based Program” means an outcomes-based payment arrangement and/or coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

3. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, Company will include any such surcharge, tax or other fee as part of the claim charge passed on to the Member.

4. Non-Network Providers Outside Company’s Service Area

a. Member Liability Calculation

When Covered Services are provided outside of Company’s service area by Non-Network Providers, the amount the Member’s pays for such services will generally be based on either the Host Blue's Non-Network Provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be liable for the difference between the amount that the Non-Network Provider bills and the payment Company will make for the covered services as set forth in this paragraph. Federal or state law, as applicable, will govern benefit levels for Non-Network Emergency services.

b. Exceptions

In certain situations, Company may use other payment methods, such as billed covered charges, the payment Company would make if the healthcare services had been obtained within Company’s service area, or a special negotiated payment to determine the amount Company will pay for services provided by Non-Network Providers. In these situations, the Member may be liable for the difference between the amount that the Non-Network Provider bills and the payment Company will make for the covered services as set forth in this paragraph.

5. Blue Cross Blue Shield Global Core

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter “BlueCard service area”), you may be able to take

advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

a. Inpatient Services

   In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your deductibles, coinsurance, etc. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. **You must contact the Company to obtain precertification for non-emergency inpatient services.**

b. Outpatient Services

   Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

c. Submitting a Blue Cross Blue Shield Global Core Claim

   When the Member pays for Covered Services outside the BlueCard service area, the Member must submit a claim to obtain reimbursement. For institutional and professional claims, the Member should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the service center address on the form to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of the Member's claim. The claim form is available from Company, the service center or online at www.bcbsglobalcore.com. If the Member needs assistance with the Member's claim submission, the Member should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

Provider Network Directory

The Member may request a copy of the Network Provider Directory by visiting Company's web site at www.bcbsms.com. This directory includes Physicians, Hospitals, and Allied Providers that have a Provider agreement with Company. This directory will be provided at no charge to the Member.

Qualified Medical Child Support Orders

The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) mandates that group health plans provide Benefits according to Qualified Medical Child Support Order (QMCSO) requirements. QMCSO's are judgments, decrees, or court orders that create or recognize a child's right to receive benefits under a group health plan. QMCSO's must contain:

1. The name and last known address of the participant and each covered by the order;

2. Type of coverage the group will provide to each child;

3. The period of time that the order covers; and

4. Each plan (medical, dental)

The Member may request from the Group the written procedures for QMCSO. This information is available at no charge to the Member.

Identity Theft Protection

If your employer chooses to participate in the Identity Theft Protection program, Identity Theft Protection may be available through the Company's contract with an identity theft provider for all eligible Members at no cost to the Member. Identity protection will include the following components:

1. Credit monitoring – Monitors activity that may affect credit;

2. Identity Theft Monitoring – Identifies potentially fraudulent use of identity or credit;

3. Credit/identity repair – Provides assistance in repairing identity or credit.

Proxy Statement

As a part of the Subscriber's enrollment for membership and coverage with Blue Cross & Blue Shield of Mississippi (whether through enrollment form or electronic transmission), he or she has appointed Blue Cross & Blue Shield of Mississippi's President, Executive Vice President, and Secretary as proxies to cast his or her vote, upon concurrence of at least two of them, on all matters arising at membership meetings. Their appointments shall remain in effect unless and until the Subscriber files a written revocation with Blue Cross & Blue Shield of Mississippi's Secretary by submitting a written notification to Blue Cross & Blue Shield of Mississippi addressed to: Secretary, Blue Cross & Blue Shield of Mississippi, 3545 Lakeland Drive, Flowood, MS 39232.

Member Rights and Responsibilities

As a member of Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company (BCBSMS) you have certain rights and responsibilities. As your partner on your health and wellness journey, BCBSMS is committed to protecting the rights afforded to you as a BCBSMS Member.

You have the right to:

- Receive information from BCBSMS including the services we provide and our Network Providers.
- Be treated with respect and dignity.
- Have your information maintained privately and securely in accordance with BCBSMS' Privacy Practices.
- Work with your Network Provider in making decisions about your healthcare.
- Speak freely and privately with your Network Provider about all healthcare options and treatments for your condition regardless of the cost or whether treatments are covered under the Health & Wellness Benefit Plan.
- File a complaint or Appeal regarding decisions that we make.
- Make recommendations regarding your rights and responsibilities.

It is your responsibility to:

- Read information provided to you by BCBSMS and inquire if you do not understand.
- Supply information as needed by BCBSMS or your Network Provider.
- Follow plans and instructions given to you by your Network Provider.
- Follow the rules of your Health and Wellness Benefit Plan.
- Understand your health and participate with your Network Provider and BCBSMS in developing a treatment plan and goals.
- Keep BCBSMS informed of changes such as changes to your address, telephone number and email address so we can contact you.
- Treat BCBSMS employees and your Network Providers with respect.
- Keep all scheduled appointments where possible.
- Work with your Network Provider before making any changes to your treatment plan or care.
- Utilize *my*Blue to access information regarding your Health and Wellness Benefit Plan.

Should you have any questions regarding your rights and responsibilities, please contact our Health and Wellness Team at 601-664-4590 or 800-942-0278.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Summary of Privacy Practices

We may use and disclose your medical information, without your permission, for treatment, payment, and health care operations activities and, when required or authorized by law, for public health and interest activities, law enforcement, judicial and administrative proceedings, research, and certain other public benefit functions.

We may disclose your medical information to your spouse and others you involve in your health care or payment for health care, and to appropriate public and private agencies in disaster relief situations.

We may disclose to your employer whether you are enrolled or disenrolled in the health plans it sponsors, summary health information for certain limited purposes, and your medical information for your employer to administer your group health plan if your employer explains the limitations on its use and disclosure of your medical information in the plan document for your group health plan.

We will not otherwise use or disclose your medical information without your written authorization.

You have the right to examine and receive a copy of your medical information, to receive an accounting of certain disclosures we may make of your medical information, and to request that we amend, further restrict use and disclosure of, or communicate in confidence with you about your medical information.

We are prohibited by federal law from using or disclosing certain information about your substance use disorders, unless you consent to the use and disclosure. In most cases, you may give consent through the treating provider.

We cannot use or disclose information about your treatment for substance use disorders (or provide testimony based on such information) for any civil, criminal, administrative, or legislative proceedings against you, unless you consent or we have received a subpoena, court order, or a similar legal mandate, and you have had notice and an opportunity to object.

Once we disclose information to a third party other than a health care provider, health plan, or other person subject to federal privacy laws, the information may no longer be protected by federal privacy laws and the recipient may use or redisclose that information for other purposes.

Please review this entire notice for details about the uses and disclosures we may make of your medical information, about your rights and how to exercise them, and about complaints regarding or additional information about our privacy practices.

Our Legal Duty

We are required by applicable federal and state law, including 42 C.F.R. Part 2, to maintain the privacy of your medical information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect unless we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we maintain, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and send the new notice to our health plan subscribers at the time of the change.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information at the end of this notice.

Uses and Disclosures of Medical Information

Treatment: We may disclose your medical information, without your permission, to a physician or other health care provider to treat you.

Payment: We may use and disclose your medical information, without your permission, to pay claims from physicians, hospitals and other health care providers for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate your benefits with other payers, to determine the medical necessity of care delivered to you, to obtain premiums for your health coverage, to issue explanations of benefits to the subscriber of the health plan in which you participate, and the like. We may disclose your medical information to a health care provider or another health plan for that provider or plan to obtain payment or engage in other payment activities.

Health Care Operations: We may use and disclose your medical information, without your permission, for health care operations. Health care operations include:

- health care quality assessment and improvement activities;
- reviewing and evaluating health care provider and health plan performance, qualifications and competence, health care training programs, health care provider and health plan accreditation, certification, licensing and credentialing activities;

- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention;

- underwriting and premium rating our risk for health coverage, and obtaining stop-loss and similar reinsurance for our health coverage obligations (although we are prohibited from using or disclosing any genetic information for these underwriting purposes); and

- business planning, development, management, and general administration, including customer service, grievance resolution, claims payment and health coverage improvement activities, de-identifying medical information, and creating limited data sets for health care operations, public health activities, and research.

We may disclose your medical information to another health plan or to a health care provider subject to federal privacy protection laws, as long as the plan or provider has or had a relationship with you and the medical information is for that plan's or provider's health care quality assessment and improvement activities, competence and qualification evaluation and review activities, or fraud and abuse detection and prevention.

Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. To the extent (if any) that we maintain or receive psychotherapy notes about you, most disclosures of these notes require your authorization. In addition, most (but not all) uses and disclosures of medical information for marketing purposes, and disclosures that constitute a sale of protected health information, require your authorization. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice.

Spouses and Others Involved in Your Care or Payment for Care: We may disclose your medical information to a spouse covered under your benefit plan. We will disclose only the medical information that is relevant to your spouse's involvement. We may use or disclose your name, location, and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your health care in appropriate situations, such as a medical emergency or during disaster relief efforts.

If you are present at the time of disclosure, we will provide you with an opportunity to object. If you are not present or are incapacitated or it is an emergency or disaster relief situation, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

Your Employer: We may disclose to your employer whether you are enrolled or disenrolled in a health plan that your employer sponsors. We may disclose summary health information to your employer to use to obtain premium bids for the health insurance coverage offered under the group health plan in which you participate or to decide whether to modify, amend or terminate that group health plan. Summary health information is aggregated claims history, claims expenses or types of claims experienced by the enrollees in your group health plan. Although summary health information will be stripped of all direct identifiers of these enrollees, it still may be

possible to identify medical information contained in the summary health information as yours.

We may disclose your medical information and the medical information of others enrolled in your group health plan to your employer to administer your group health plan. Before we may do that, your employer must amend the plan document for your group health plan to establish the limited uses and disclosures it may make of your medical information. Please see your group health plan document for a full explanation of those limitations.

Health-Related Products and Services: Where permitted by law, we may use your medical information to communicate with you about health-related products, benefits and services, and payment for those products, benefits and services, that we provide or include in our benefits plan, and about treatment alternatives that may be of interest to you. These communications may include information about the health care providers in our network, about replacement of or enhancements to your health plan, and about health-related products or services that are available only to our enrollees that add value to, although they are not part of, our benefits plan.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and interest activities, judicial and administrative proceedings, law enforcement, research, and other public benefit functions:

- for public health, including to report disease and vital statistics, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud prevention enforcement agencies;
- for research;
- in response to court and administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims, crimes on our premises, crime reporting in emergencies, and identifying or locating suspects or other persons;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and
- as authorized by state worker’s compensation laws.

Individual Rights

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. You must make a written request to obtain access to your medical information. You should submit your request to the contact at the end of this notice. You may obtain a form from that contact to make your request. This may include an electronic copy in certain circumstances if you make this request in writing.

We may charge you reasonable, cost-based fees for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact us using the information at the end of this notice for information about our fees.

Disclosure Accounting: You have the right to a list of instances in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities.

You should submit your request to the contact at the end of this notice. You may obtain a form from that contact to make your request. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to your additional requests. Contact us using the information at the end of this notice for information about our fees.

Amendment: You have the right to request that we amend your medical information. Your request must be in writing, and it must explain why the information should be amended. You should submit your request to the contact at the end of this notice. You may obtain a form from that contact to make your request.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. We are not required to agree to your request. If we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You should submit your request to the contact at the end of this notice. You may obtain a form from that contact to make your request. Any agreement we may make to a request for restriction must be in writing signed by a person authorized to bind us to such an agreement.

Confidential Communications: You have the right to request that we communicate with you about your medical information in confidence by alternative means or to alternative locations that you specify. You must make your request in writing, and your request must represent that the information could endanger you if it is not communicated in confidence as you request. You should submit your request to the contact at the end of this notice. You may obtain a form from that contact to make your request.

We will accommodate your request if it is reasonable, specifies the alternative means or location for confidential communications, and continues to permit us to collect premiums and pay claims under your health plan, including issuance of explanations of benefits to the subscriber of that health plan. Please note that an explanation of benefits and other information that we issue to the subscriber about health care that you received for which you did not request confidential communications, or about health care received by the

subscriber or by others covered by the health plan in which you participate, may contain sufficient information to reveal that you obtained health care for which we paid, even though you requested that we communicate with you about that health care in confidence.

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information at the end of this notice to obtain this notice in written form.

Breach Notification: In the event of breach of your unsecured health information, we will provide you notification of such a breach as required by law or where we otherwise deem appropriate.

Nonpublic Personal Information

How we protect information: Except as explained below, we restrict access to nonpublic personal information about an individual to our employees who need to know that information to provide products or services to that person. We maintain physical, electronic, and procedural safeguards that comply with federal and state regulations across our organization to guard nonpublic personal information.

Information we collect and maintain: We collect nonpublic personal information about you we receive from you on applications or other forms and information about your transactions with us, our affiliate or others.

Information we disclose: We may disclose all the information we collect as described above.

Information we share: We may share this information with affiliated companies and nonaffiliated third parties to perform services or functions on our behalf but otherwise we do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted by law. When we make disclosures of nonpublic personal information, except for those disclosures permitted by law, we require non-affiliated third parties to protect the confidentiality of such information and to use it solely for the purpose for which we disclosed the information.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information at the end of this notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, in response to a request

you made to amend, restrict the use or disclosure of, or communicate in confidence about your medical information, you may complain to us using the contact information at the end of this notice. You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, D.C. 20201. You may contact the Office of Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Office
Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company
3545 Lakeland Drive
Flowood, MS 39232
Telephone: 601-664-5456
Fax: 601-664-4172