

Health Reimbursement Arrangement (HRA)	Individual	Family
<b>HRA Allocation</b> <sup>[18]</sup>	\$1000	\$2000
<b>HRA Covers</b>	Medical Only Expenses	
<b>HRA Eligible Expenses</b>	Deductible	
<b>HRA Reimbursement Order</b>	Employee pays first \$1000 Individual/\$2000 Family before the HRA reimburses.	
<b>HRA Reimbursement Percentage</b>	100%	
Benefit Plan Features	Your Cost In-Network	Your Cost Out-Of-Network <sup>[1]</sup>
<b>Annual Deductible</b>		
Individual/Family	\$2000/\$4000	\$4000/\$8000
<b>Annual Out-of-Pocket Maximum</b>		
Individual/Family	\$4000/\$8000	\$12000/\$24000
<b>4th Quarter Carry-over</b>	Excluded	
Covered Services		
<b>Preventive Care Services</b> <sup>[2]</sup> (see page 3 for a list)		
Well Child Care Services	Covered at 100%	40% after Deductible
Well Care Services <sup>[2]</sup>	Covered at 100%	40% after Deductible
Annual Well Women Exam, Mammogram	Covered at 100%	40% after Deductible
<b>Practitioner Office Services</b>		
Primary Care Office Visits	\$30 Copay	40% after Deductible
Specialist Office Visits	\$50 Copay	40% after Deductible
Office Surgery <sup>[4] [5] [6]</sup>	\$30/\$50 Copay	40% after Deductible
Routine Diagnostic Lab, X-Ray & Injections	No Additional Copay	40% after Deductible
Advanced Radiological Imaging <sup>[3] [5] [7]</sup>	20% after Deductible	40% after Deductible
Provider-Administered Specialty Drugs <sup>[11]</sup>	\$100 Copay	40% after Deductible
<b>Services Received at a Facility</b>		
(includes professional and facility charges)		
Inpatient Services <sup>[3] [5]</sup>	20% after Deductible	40% after Deductible
Outpatient Surgery <sup>[4] [5] [6]</sup>	20% after Deductible	40% after Deductible
Routine Diagnostic Services - Outpatient	100% (no Deductible)	40% after Deductible
Advanced Radiological Imaging - Outpatient <sup>[3] [5] [7]</sup>	20% after Deductible	40% after Deductible
Other Outpatient Services <sup>[8]</sup>	20% after Deductible	40% after Deductible
Emergency Care Services <sup>[9]</sup>	\$250 ER Copay	\$250 ER Copay
Emergency Care Advanced Radiological Imaging <sup>[7]</sup>	20% after Deductible	20% after Deductible
<b>Medical Equipment</b> <sup>[4]</sup>		
Durable Medical Equipment	20% after Deductible	40% after Deductible
Prosthetics	20% after Deductible	40% after Deductible
Orthotic Appliances	20% after Deductible	40% after Deductible
Hearing Aids	20% after Deductible	40% after Deductible
<b>Behavioral Health</b>		
Inpatient: Unlimited days per annual benefit period <sup>[3] [5]</sup>	20% after Deductible	40% after Deductible
Outpatient: Unlimited visits per annual benefit period	\$30 Copay	40% after Deductible
<b>Therapy Services</b> <sup>[10]</sup>		
Limited to 30-36 visits per annual benefit period per therapy type	20% after Deductible	40% after Deductible
<b>Skilled Nursing Facility &amp; Rehabilitation Facility Services</b> <sup>[3] [5]</sup>		
Limited to 60 days combined	20% after Deductible	40% after Deductible
<b>Home Health Care Services</b> <sup>[3]</sup>		
Limited to 60 visits per annual benefit period	20% after Deductible	40% after Deductible

Benefit Plan Features:	Your Cost In-Network	Your Cost Out-Of-Network <sup>[1]</sup>
<b>Hospice Services</b>		
Inpatient <sup>[3]</sup>	Covered at 100%	40% after Deductible
Outpatient	Covered at 100%	40% after Deductible
<b>Ambulance Service</b>	20% after Deductible	20% after Deductible
<b>Prescription Drugs <sup>[4]</sup></b>		
<b>Prescription Contraceptives <sup>[16]</sup></b>	Covered at 100%	40% after Deductible
<b>Retail RX04 Network - up to 30 day supply</b>		
Generic <sup>[13] [15] [17]</sup>	\$10.00	40% after Deductible
Preferred <sup>[13] [15] [17]</sup>	\$25.00	40% after Deductible
Non-Preferred <sup>[13] [15] [17]</sup>	\$50.00	40% after Deductible
<b>Plus90 or Home Delivery Network</b>		
Generic <sup>[14] [15]</sup>	\$20.00	40% after Deductible
Preferred <sup>[14] [15]</sup>	\$50.00	40% after Deductible
Non-Preferred <sup>[14] [15]</sup>	\$100.00	40% after Deductible
<b>Self-Administered Specialty Drug <sup>[11] [12] [15]</sup></b>		
Specialty Pharmacy Network - up to 30 day supply	\$100.00	Not Covered

**Notes:**

1. Out-of-network benefit payment based on BlueCross BlueShield of Tennessee maximum allowable charge. You are responsible for paying any amount exceeding the maximum allowable charge.
2. Services include: annual physical, childhood immunizations, recommended adult immunizations, vision and hearing screenings performed by the physician during the preventive health exam.
3. Requires prior authorization.
4. Certain procedures, medication and equipment may require prior authorization.
5. If prior authorization is required, when using network providers outside Tennessee for physician and outpatient services and all services from out-of-network providers, benefits will be reduced by 10% based on out-of-network if prior authorization is not obtained and services are medically necessary. If services are not medically necessary, no benefits will be provided.
6. Surgeries include incisions, excisions, biopsies, injection treatments, fracture treatments, applications of casts and splints, sutures, and invasive diagnostic services (e.g., colonoscopy, sigmoidoscopy and endoscopy).
7. CT scans, PET scans, MRIs, nuclear medicine and other similar technologies.
8. Includes services such as chemotherapy, radiation therapy and renal dialysis.
9. Copay, if applicable, waived if admitted to hospital.
10. Physical, speech, manipulative, and occupational therapies are limited to 30 visits per therapy type per annual benefit period. Cardiac and pulmonary rehabilitative therapies are limited to 36 visits per therapy type per annual benefit period.
11. Visit [bcbst.com](http://bcbst.com) for the Specialty Drug List.
12. You have a distinct arrangement for Self-administered Specialty Drugs. To receive benefits, you must use a Specialty Pharmacy Network provider. Visit [bcbst.com](http://bcbst.com) for a list of providers in the Specialty Pharmacy Network. Specialty drugs are limited to a 30-day supply.
13. Copay per prescription, up to 30 day supply.
14. Your plan requires you to receive long-term medications in a 90-day supply from home delivery or at a retail pharmacy in the Plus90 network. If you choose to use a retail pharmacy that is not part of the Plus90 Network, you are limited to a 30-day supply. Visit [bcbst.com](http://bcbst.com) to find a list of pharmacies in the Plus90 network.
15. A financial penalty may be applied if you choose a brand name drug when a generic equivalent is available. Please refer to your Evidence of Coverage (EOC) for specific information.
16. This plan covers the following at 100%, in accordance with the Women's Preventive Services provision of the Affordable Care Act: generic contraceptives, vaginal ring, hormonal patch, emergency contraception available with a prescription. Visit [bcbst.com](http://bcbst.com) for a complete list of covered prescription contraceptive drugs.
17. Vaccines administered at the pharmacy are covered at 100%.
18. HRA Plan: Your HRA allocation is embedded, which means each covered individual in a family plan has a per member limit up to the amount noted in the individual tier and to the family maximum for all members combined. If your BlueCross HRA becomes effective in month other than January, your annual allocation may be prorated.

**Limitations and Exclusions.** These pages summarize the benefits of your health care plan. Your Evidence of Coverage (EOC) and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the EOC will govern. For a complete list of limitations and exclusions, please refer to your EOC.

# Summary of Preventive Health Services Covered at 100% In-Network

## In-network preventive services that are covered with no cost share include:

- Primary care services with an A or B recommendation by the United States Preventive Services Task Force (USPSTF)
- Immunizations recommended by the Advisory Committee on Immunization Practices that have been adopted by the Centers for Disease Control and Prevention (CDC)
- Bright Futures recommendations for infants, children and adolescents that are supported by the Health Resources and Services Administration (HRSA)
- Preventive care and screening for women as provided in the guidelines supported by HRSA

## The following preventive care services are covered. Coverage of some services may depend on age and/or risk exposure.

### All Members:

- One-a-year preventive health exams. More frequent preventive exams are covered for children up to age 3
- All standard immunizations adopted by the CDC
- Screening for colorectal cancer (age 50 – 75), high cholesterol and lipids, high blood pressure, obesity, diabetes, and depression
- Screening for HIV and certain sexually transmitted diseases, and counseling for the prevention of sexually transmitted diseases
- Screening and counseling in primary care setting for alcohol misuse and tobacco use; tobacco cessation counseling in the primary care setting will be limited to eight visits per year
- Dietary counseling for adults with hyperlipidemia, hypertension, Type 2 diabetes, obesity, coronary artery disease and congestive heart failure; limited to six visits per year

### Women:

- Annual well-woman visit, including annual sexually transmitted infection (STI) counseling and annual domestic violence screening & counseling
- Cervical Cancer Screening
- Screening of pregnant women for anemia, iron deficiency, bacteriuria, hepatitis B virus, Rh factor incompatibility, gestational diabetes
- Breastfeeding support/counseling & supplies (one lactation consultant visit and manual breast pump in conjunction with each birth)
- Counseling women at high risk of breast cancer for chemoprevention, including risks and benefits
- Mammography screening at age 40 and over, and evaluation for genetic testing for BRCA breast cancer gene
- Osteoporosis screening (age 60 or older)
- HPV testing once every 3 years, beginning at age 30
- Annual HIV screening and counseling
- FDA-approved contraceptive methods and counseling Medical plan: Injectable or implantable hormonal contraceptives and barrier methods, sterilization for women Rx plan: Generic oral & injectable contraceptives, vaginal contraceptive, patch, prescription emergency contraception

### Men:

- Prostate cancer screening at age 50 and older
- Abdominal aortic aneurysm screening at age 65 – 75 (for men who have ever smoked)

### Children:

- Newborn screening for hearing, phenylketonuria (PKU), thyroid disease, sickle cell anemia, and cystic fibrosis
- Development delays and autism screening
- Iron deficiency screening
- Vision screening
- Screening for major depressive disorders