

**City of Gallatin**  
**BlueCross BlueShield of Tennessee**  
**Effective 10-1-2012**

Benefits	Option 1	Option 2	Option 3						
PPO NETWORKS	Basic (S Network)	Enhanced (P Network)	Basic (S Network)						
Individual Deductible (2x Family)	\$1,500 (\$1,000 Employee + \$500 City)	\$1,500 (\$1,000 Employee + \$500 City)	\$1,250 (\$750 Employee + \$500 City)						
Coinsurance (In Network)	Ins. 80% / Employee 20%	Ins. 80% / Employee 20%	Ins. 90% / Employee 10%						
(Out of Network)	Ins. 60% / Employee 40%	Ins. 60% / Employee 40%	Ins. 70% / Employee 30%						
Individual Out of Pocket	\$2,500 (Includes Deductible) (\$2,000 Employee + \$500 City)	\$2,500 (Includes Deductible) (\$2,000 Employee + \$500 City)	\$2,500 (Includes Deductible) (\$2,000 Employee + \$500 City)						
Preventive Care Office Visit Copay	100% (No Copay)	100% (No Copay)	100% (No Copay)						
Sickness/Injury Office Visit Copay(1)	\$20	\$20	\$20						
Sickness/Injury Office Visit Copay(2)	\$40	\$40	\$40						
Outpatient Surgery	Deductible/Coinsurance	Deductible/Coinsurance	100%						
Inpatient Hospitalization	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance						
Routine Diagnostics (Labwork, X-rays, etc.)	100%	100%	100%						
Advanced Diagnostics (MRI, CT, PET, Nuclear, MRA)	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance						
Emergency Room Copay	\$250	\$250	\$250						
Prescription Drug Card	\$10/\$25/50	\$10/\$25/50	\$10/\$25/50						
<b>*You will be able to get a 3 month supply of your maintenance drugs for the cost of a 2 month supply. (Applies to all options)</b>									
Mental Health	Outpatient: \$20 Copay	Outpatient: \$20 Copay	Outpatient: \$20 Copay						
Substance Use Disorder	Inpatient: Ded/Coinsurance	Inpatient: Ded/Coinsurance	Inpatient: Ded/Coinsurance						
Preventive Health Care Services	100%	100%	100%						
Vision Coverage	Vision Care #2 (\$20 copay)	Vision Care #2 (\$20 copay)	Vision Care #2 (\$20 copay)						
Ambulance Services	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance						
Durable Medical Equipment	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance						
Hearing Aids (frequency every 2 yrs)	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance						
Home Health Care (60 visits)	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance						
Hospice Care	100%	100%	100%						
Prosthetic Devices	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance						
Skilled Nursing Facility & Rehab Facility Services (60 days per yr)	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance						
Therapeutic Services (Physical, Speech, Chiropractic, etc.) 30-36 visits	\$40	\$40	\$40						
Therapeutic Treatments (Dialysis, Chemo, Radiation, etc.)	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance						
Transplantation Services	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance						
Lifetime Max. (In & Out)	Unlimited	Unlimited	Unlimited						
<b>Employee Rates</b>	<b>Option 1</b>		<b>Option 2</b>		<b>Option 3</b>				
		Monthly	Biweekly	Monthly	Biweekly	Monthly	Biweekly		
	EE Only	\$0.00	\$0.00	EE Only	\$41.05	\$20.53	EE Only	\$41.87	\$20.94
	EE + SP	\$244.22	\$122.11	EE + SP	\$330.42	\$165.21	EE + SP	\$332.15	\$166.07
	EE + CH	\$220.23	\$110.12	EE + CH	\$295.35	\$147.68	EE + CH	\$296.84	\$148.42
	EE/SP/CH	\$305.35	\$152.68	EE/SP/CH	\$429.94	\$214.97	EE/SP/CH	\$432.43	\$216.22

(1) The \$20 copay applies to Family Practice, General Practice, Internal Medicine, OB/GYN, Pediatrics, Nurse Practitioners/Physician Assistants.  
(2) The \$40 copay applies to Specialists.

Only the P network includes Tri-Star/HCA Facilities such as Centennial, Skyline, Summitt, and Hendersonville Med. Ctr.  
Dependent Children Age Limit to age 26.

The above reflects In-Network benefits only. Out-of-Network benefits are different.

Some Prescription Drugs may be in lower or higher co-pay tiers than presently.

BCBST does have a separate higher copay for specialty drugs.

\*This is for summary purposes only. Refer to the Certificate of Coverage (COC) for exact details.\*

**City of Gallatin**  
**BlueCross BlueShield of Tennessee**  
**Effective 10-1-2012**

<b>BCBST OPTION 1</b>		<b>Firm Monthly</b>	<b>City Monthly</b>	<b>Employee Monthly</b>	<b>Employee Biweekly</b>
Employee Only	1/E	\$403.99	\$403.99	\$0.00	\$0.00
Employee + Spouse	1/E+SP	\$847.69	\$603.47	\$244.22	\$122.11
Employee + Child/ren	1/E+CH	\$738.78	\$518.55	\$220.23	\$110.12
Full Family	1/F	\$1,224.83	\$919.48	\$305.35	\$152.68

<b>BCBST OPTION 2</b>		<b>Firm Monthly</b>	<b>City Monthly</b>	<b>Employee Monthly</b>	<b>Employee Biweekly</b>
Employee Only	2/E	\$445.04	\$403.99	\$41.05	\$20.53
Employee + Spouse	2/E+SP	\$933.89	\$603.47	\$330.42	\$165.21
Employee + Child/ren	2/E+CH	\$813.90	\$518.55	\$295.35	\$147.68
Full Family	2/F	\$1,349.42	\$919.48	\$429.94	\$214.97

<b>BCBST OPTION 3</b>		<b>Firm Monthly</b>	<b>City Monthly</b>	<b>Employee Monthly</b>	<b>Employee Biweekly</b>
Employee Only	3/E	\$445.86	\$403.99	\$41.87	\$20.94
Employee + Spouse	3/E+SP	\$935.62	\$603.47	\$332.15	\$166.07
Employee + Child/ren	3/E+CH	\$815.39	\$518.55	\$296.84	\$148.42
Full Family	3/F	\$1,351.91	\$919.48	\$432.43	\$216.22



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## City of Gallatin Summary of Benefits

Effective Date: 10/1/2012  
HRA-PPO Network; S.  
Option: 1

Benefit Highlights	In-Network Benefits	Out-of-Network Benefits <sup>[4]</sup>
<b>Health Reimbursement Arrangement (HRA)</b>		
You will receive an annual HRA allocation from your employer to help meet your annual Deductible responsibility.		
HRA Allocation: <sup>[1]</sup>	\$500 Individual/\$1000 Family	
HRA Reimbursement Order:	Employee pays first \$1000 Individual/\$2000 Family deductible before the HRA reimburses.	
HRA Reimbursement Method:	Automatic Reimbursement	
<b>Annual Deductible</b>		
Individual	\$1,500	\$3,000
Family	\$3,000	\$6,000
<b>Annual Out-of-Pocket Maximum</b>		
Individual	\$2,500	\$7,500
Family	\$5,000	\$15,000
<b>Lifetime Maximum</b>		Unlimited
<b>Dependent Age Limit</b>		To age 26
<b>Pre-Existing Condition Waiting Period <sup>[2]</sup></b>		12 months
<b>4th Quarter Deductible Carryover Provision</b>		Not Included
<b>Office Visits</b>		
Office Visits <sup>[3]</sup>	\$20/\$40 Copay	60% after Deductible
Office Surgery <sup>[6]</sup> <sup>[7]</sup> <sup>[8]</sup>	80% after Deductible	60% after Deductible
Routine Diagnostic Lab, X-Ray & Injections	No Additional Copay	60% after Deductible
Advanced Radiological Imaging <sup>[5]</sup> <sup>[7]</sup> <sup>[9]</sup>	80% after Deductible	60% after Deductible
Provider-Administered Specialty Drugs <sup>[14]</sup>	\$100 Copay	60% after Deductible
<b>Preventive Health Care Services</b>		
Well Child Care (to age 6)	100%	60% after Deductible
Annual Well Woman Exam	100%	60% after Deductible
Annual Mammography Screening, age 40+	100%	60% after Deductible
Annual Cervical Cancer Screening	100%	60% after Deductible
Annual Prostate Cancer Screening, age 50+	100%	60% after Deductible
Immunizations	100%	60% after Deductible
Well Care Services (ages 6 and up) <sup>[16]</sup>	100%	60% after Deductible
<b>Services Received at a Facility (includes professional and facility charges)</b>		
Inpatient Services <sup>[5]</sup> <sup>[7]</sup>	80% after Deductible	60% after Deductible
Outpatient Surgery <sup>[6]</sup> <sup>[7]</sup> <sup>[8]</sup>	80% after Deductible	60% after Deductible
Routine Diagnostic Services-Outpatient	100% (no Deductible)	60% after Deductible
Advanced Radiological Imaging-Outpatient <sup>[5]</sup> <sup>[7]</sup> <sup>[9]</sup>	80% after Deductible	60% after Deductible
Provider-Administered Specialty Drugs <sup>[14]</sup>	80% after Deductible	60% after Deductible
Other Outpatient Services <sup>[10]</sup>	80% after Deductible	60% after Deductible
Emergency Care Services <sup>[12]</sup>	\$250 ER Copay	\$250 ER Copay
Emergency Care Advanced Radiological Imaging <sup>[9]</sup>	80% after Deductible	80% after Deductible
<b>Medical Equipment</b>		
Durable Medical Equipment	80% after Deductible	60% after Deductible
Prosthetics	80% after Deductible	60% after Deductible
Orthotic Appliances	80% after Deductible	60% after Deductible
<b>Behavioral Health</b>		
Inpatient: Unlimited days per annual benefit period	80% after Deductible	60% after Deductible
Outpatient: Unlimited visits per annual benefit period	\$20 Copay per visit	60% after Deductible
<b>Therapeutic Services <sup>[11]</sup></b>		
Therapy (Limited to 20-36 visits per annual benefit period per therapy type)	80% after Deductible	60% after Deductible
<b>Skilled Nursing Facility &amp; Rehabilitation Facility Services <sup>[9]</sup> <sup>[7]</sup></b>		
Limited to 60 days combined	80% after Deductible	60% after Deductible
<b>Home Health Services <sup>[9]</sup></b>		
Limited to 60 visits per annual benefit period	80% after Deductible	60% after Deductible
<b>Hospice Services</b>	100%	60% after Deductible
<b>Ambulance Service</b>	80% after Deductible	80% after Deductible
<b>Pharmacy</b>		
Prescription Drugs <sup>[13]</sup> <sup>[15]</sup>	\$10 / \$25 / \$50 Copays	
Specialty Drugs <sup>[13]</sup> <sup>[14]</sup> <sup>[15]</sup>	Preferred Vendors - \$100 Copay / Non-Preferred Vendors - \$200 Copay	

**Notes:**

1. If your BCBS HRA plan becomes effective in a month other than January, your annual allocation may be prorated.
2. HIPAA regulations apply. A Group enrollee's pre-existing condition waiting period can be reduced by the enrollee's applicable "creditable coverage". Pre-existing condition waiting period does not apply to enrollees under age 19.
3. The lower copay applies to Family Practice, General Practice, Internal Medicine, OB/Gyn, Pediatrics, Nurse Practitioners and Physician Assistants.
4. 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.
5. Requires prior authorization.
6. Certain Outpatient Surgeries and/or procedures may require prior authorization.
7. If prior authorization is required, when using network providers outside Tennessee and all out-of-network providers, benefits will be reduced to 50% if prior authorization is not obtained and services are medically necessary. If services are not medically necessary no benefits will be provided.
8. 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).
9. CAT scans, PET Scans, MRIs, nuclear medicine and other similar technologies.
10. Includes services such as chemotherapy, radiation therapy, and renal dialysis.
11. Physical, speech, manipulative, and occupational therapies are limited to 20 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.
12. Copay, if applicable, waived if admitted to hospital.
13. See attached rider for Pharmacy exclusions and Specialty Drug vendors.
14. Refer to www.bcbst.com for Specialty Pharmacy Drug List.
15. Copay per prescription, up to 30 day supply.
16. Services include: annual physical, childhood immunizations, recommended adult immunizations, vision and hearing screenings performed by the physician during the preventive health exam.
17. This is a grandfathered health plan, as permitted by the Affordable Care Act. Please refer to your employer and your Evidence of Coverage for more information.



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## City of Gallatin Summary of Benefits

Effective Date: 10/1/2012  
HRA-PPO Network: P  
Option: 2

Benefit Highlights	In-Network Benefits	Out-of-Network Benefits <sup>[1]</sup>
<b>Health Reimbursement Arrangement (HRA)</b>		
You will receive an annual HRA allocation from your employer to help meet your annual Deductible responsibility.		
HRA Allocation: <sup>[1]</sup>	\$500 Individual/\$1000 Family	
HRA Reimbursement Order:	Employee pays first \$1000 Individual/\$2000 Family deductible before the HRA reimburses.	
HRA Reimbursement Method:	Automatic Reimbursement	
<b>Annual Deductible</b>		
Individual	\$1,500	\$3,000
Family	\$3,000	\$6,000
<b>Annual Out-of-Pocket Maximum</b>		
Individual	\$2,500	\$7,500
Family	\$5,000	\$15,000
<b>Lifetime Maximum</b>		Unlimited
<b>Dependent Age Limit</b>		To age 26
<b>Pre-Existing Condition Waiting Period <sup>[2]</sup></b>		12 months
<b>4th Quarter Deductible Carryover Provision</b>		Not Included
<b>Office Visits</b>		
Office Visits <sup>[3]</sup>	\$20/\$40 Copay	60% after Deductible
Office Surgery <sup>[6]</sup> <sup>[7]</sup> <sup>[8]</sup>	80% after Deductible	60% after Deductible
Routine Diagnostic Lab, X-Ray & Injections	No Additional Copay	60% after Deductible
Advanced Radiological Imaging <sup>[5]</sup> <sup>[7]</sup> <sup>[9]</sup>	80% after Deductible	60% after Deductible
Provider-Administered Specialty Drugs <sup>[14]</sup>	\$100 Copay	60% after Deductible
<b>Preventive Health Care Services</b>		
Well Child Care (to age 6)	100%	60% after Deductible
Annual Well Woman Exam	100%	60% after Deductible
Annual Mammography Screening, age 40+	100%	60% after Deductible
Annual Cervical Cancer Screening	100%	60% after Deductible
Annual Prostate Cancer Screening, age 50+	100%	60% after Deductible
Immunizations	100%	60% after Deductible
Well Care Services (ages 6 and up) <sup>[18]</sup>	100%	60% after Deductible
<b>Services Received at a Facility (Includes professional and facility charges)</b>		
Inpatient Services <sup>[5]</sup> <sup>[7]</sup>	80% after Deductible	60% after Deductible
Outpatient Surgery <sup>[6]</sup> <sup>[7]</sup> <sup>[8]</sup>	80% after Deductible	60% after Deductible
Routine Diagnostic Services-Outpatient	100% (no Deductible)	60% after Deductible
Advanced Radiological Imaging-Outpatient <sup>[5]</sup> <sup>[7]</sup> <sup>[9]</sup>	80% after Deductible	60% after Deductible
Provider-Administered Specialty Drugs <sup>[14]</sup>	80% after Deductible	60% after Deductible
Other Outpatient Services <sup>[10]</sup>	80% after Deductible	60% after Deductible
Emergency Care Services <sup>[12]</sup>	\$250 ER Copay	\$250 ER Copay
Emergency Care Advanced Radiological Imaging <sup>[9]</sup>	80% after Deductible	80% after Deductible
<b>Medical Equipment</b>		
Durable Medical Equipment	80% after Deductible	60% after Deductible
Prosthetics	80% after Deductible	60% after Deductible
Orthotic Appliances	80% after Deductible	60% after Deductible
<b>Behavioral Health</b>		
Inpatient: Unlimited days per annual benefit period	80% after Deductible	60% after Deductible
Outpatient: Unlimited visits per annual benefit period	\$20 Copay per visit	60% after Deductible
<b>Therapeutic Services <sup>[11]</sup></b>		
Therapy (Limited to 20-36 visits per annual benefit period per therapy type)	80% after Deductible	60% after Deductible
<b>Skilled Nursing Facility &amp; Rehabilitation Facility Services <sup>[5]</sup> <sup>[7]</sup></b>		
Limited to 60 days combined	80% after Deductible	60% after Deductible
<b>Home Health Services <sup>[5]</sup></b>		
Limited to 60 visits per annual benefit period	80% after Deductible	60% after Deductible
<b>Hospice Services</b>	100%	60% after Deductible
<b>Ambulance Service</b>	80% after Deductible	80% after Deductible
<b>Pharmacy</b>		
Prescription Drugs <sup>[13]</sup> <sup>[15]</sup>	\$10 / \$25 / \$50 Copays	
Specialty Drugs <sup>[13]</sup> <sup>[14]</sup> <sup>[15]</sup>	Preferred Vendors - \$100 Copay / Non-Preferred Vendors - \$200 Copay	

**Notes:**

- If your BCBST HRA plan becomes effective in a month other than January, your annual allocation may be prorated.
- HIPAA regulations apply. A Group enrollee's pre-existing condition waiting period can be reduced by the enrollee's applicable 'creditable coverage'. Pre-existing condition waiting period does not apply to enrollees under age 19.
- The lower copay applies to Family Practice, General Practice, Internal Medicine, OB/Gyn, Pediatrics, Nurse Practitioners and Physician Assistants.
- 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.
- Requires prior authorization.
- Certain Outpatient Surgeries and/or procedures may require prior authorization.
- If prior authorization is required, when using network providers outside Tennessee and all out-of-network providers, benefits will be reduced to 50% if prior authorization is not obtained and services are medically necessary. If services are not medically necessary no benefits will be provided.
- 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).
- CAT scans, PET Scans, MRIs, nuclear medicine and other similar technologies.
- Includes services such as chemotherapy, radiation therapy, and renal dialysis.
- Physical, speech, manipulative, and occupational therapies are limited to 20 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.
- Copay, if applicable, waived if admitted to hospital.
- See attached rider for Pharmacy exclusions and Specialty Drug vendors.
- Refer to www.bcbst.com for Specialty Pharmacy Drug List.
- Copay per prescription, up to 30 day supply.
- Services include: annual physical, childhood immunizations, recommended adult immunizations, vision and hearing screenings performed by the physician during the preventive health exam.
- This is a grandfathered health plan, as permitted by the Affordable Care Act. Please refer to your employer and your Evidence of Coverage for more information.



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## City of Gallatin Summary of Benefits

Effective Date: 10/1/2012

HRA-PPO Network: S

Option: 3

Benefit Highlights	In-Network Benefits	Out-of-Network Benefits <sup>(4)</sup>
<b>Health Reimbursement Arrangement (HRA)</b>		
You will receive an annual HRA allocation from your employer to help meet your annual Deductible responsibility.		
<b>HRA Allocation:</b> <sup>(1)</sup>	\$500 Individual/\$1000 Family	
<b>HRA Reimbursement Order:</b>	Employee pays first \$750 Individual/\$1500 Family deductible before the HRA reimburses.	
<b>HRA Reimbursement Method:</b>	Automatic Reimbursement	
<b>Annual Deductible</b>		
Individual	\$1,250	\$2,500
Family	\$2,500	\$5,000
<b>Annual Out-of-Pocket Maximum</b>		
Individual	\$2,500	\$7,500
Family	\$5,000	\$15,000
<b>Lifetime Maximum</b>		Unlimited
<b>Dependent Age Limit</b>		To age 26
<b>Pre-Existing Condition Waiting Period</b> <sup>(2)</sup>		12 months
<b>4th Quarter Deductible Carryover Provision</b>		Not Included
<b>Office Visits</b>		
Office Visits <sup>(3)</sup>	\$20/\$40 Copay	70% after Deductible
Office Surgery <sup>(6)(7)(8)</sup>	90% after Deductible	70% after Deductible
Routine Diagnostic Lab, X-Ray & Injections	No Additional Copay	70% after Deductible
Advanced Radiological Imaging <sup>(5)(7)(9)</sup>	90% after Deductible	70% after Deductible
Provider-Administered Specialty Drugs <sup>(14)</sup>	\$100 Copay	70% after Deductible
<b>Preventive Health Care Services</b>		
Well Child Care (to age 6)	100%	70% after Deductible
Annual Well Woman Exam	100%	70% after Deductible
Annual Mammography Screening, age 40+	100%	70% after Deductible
Annual Cervical Cancer Screening	100%	70% after Deductible
Annual Prostate Cancer Screening, age 50+	100%	70% after Deductible
Immunizations	100%	70% after Deductible
Well Care Services (ages 6 and up) <sup>(16)</sup>	100%	70% after Deductible
<b>Services Received at a Facility (Includes professional and facility charges)</b>		
Inpatient Services <sup>(9)(11)</sup>	90% after Deductible	70% after Deductible
Outpatient Surgery <sup>(9)(11)(9)</sup>	90% after Deductible	70% after Deductible
Routine Diagnostic Services-Outpatient	100% (no Deductible)	70% after Deductible
Advanced Radiological Imaging-Outpatient <sup>(5)(7)(9)</sup>	90% after Deductible	70% after Deductible
Provider-Administered Specialty Drugs <sup>(14)</sup>	90% after Deductible	70% after Deductible
Other Outpatient Services <sup>(10)</sup>	90% after Deductible	70% after Deductible
Emergency Care Services <sup>(12)</sup>	\$250 ER Copay	\$250 ER Copay
Emergency Care Advanced Radiological Imaging <sup>(9)</sup>	90% after Deductible	90% after Deductible
<b>Medical Equipment</b>		
Durable Medical Equipment	90% after Deductible	70% after Deductible
Prosthetics	90% after Deductible	70% after Deductible
Orthotic Appliances	90% after Deductible	70% after Deductible
<b>Behavioral Health</b>		
Inpatient: Unlimited days per annual benefit period	90% after Deductible	70% after Deductible
Outpatient: Unlimited visits per annual benefit period	\$20 Copay per visit	70% after Deductible
<b>Therapeutic Services</b> <sup>(11)</sup>		
Therapy (Limited to 20-36 visits per annual benefit period per therapy type)	90% after Deductible	70% after Deductible
<b>Skilled Nursing Facility &amp; Rehabilitation Facility Services</b> <sup>(5)(7)</sup>		
Limited to 60 days combined	90% after Deductible	70% after Deductible
<b>Home Health Services</b> <sup>(5)</sup>		
Limited to 60 visits per annual benefit period	90% after Deductible	70% after Deductible
<b>Hospice Services</b>	100%	70% after Deductible
<b>Ambulance Service</b>	90% after Deductible	90% after Deductible
<b>Pharmacy</b>		
Prescription Drugs <sup>(13)(15)</sup>	\$10 / \$25 / \$50 Copays	
Specialty Drugs <sup>(13)(14)(15)</sup>	Preferred Vendors - \$100 Copay / Non-Preferred Vendors - \$200 Copay	

**Notes:**

- If your BCBSH HRA plan becomes effective in a month other than January, your annual allocation may be prorated.
- HIPAA regulations apply. A Group enrollee's pre-existing condition waiting period can be reduced by the enrollee's applicable 'creditable coverage'. Pre-existing condition waiting period does not apply to enrollees under age 19.
- The lower copay applies to Family Practice, General Practice, Internal Medicine, OB/Gyn, Pediatrics, Nurse Practitioners and Physician Assistants.
- 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.
- Requires prior authorization.
- Certain Outpatient Surgeries and/or procedures may require prior authorization.
- If prior authorization is required, when using network providers outside Tennessee and all out-of-network providers, benefits will be reduced to 50% if prior authorization is not obtained and services are medically necessary. If services are not medically necessary no benefits will be provided.
- 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).
- CAT scans, PET Scans, MRIs, nuclear medicine and other similar technologies.
- Includes services such as chemotherapy, radiation therapy, and renal dialysis.
- Physical, speech, manipulative, and occupational therapies are limited to 20 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.
- Copay, if applicable, waived if admitted to hospital.
- See attached rider for Pharmacy exclusions and Specialty Drug vendors.
- Refer to www.bcbsd.com for Specialty Pharmacy Drug List.
- Copay per prescription, up to 30 day supply.
- Services include: annual physical, childhood immunizations, recommended adult immunizations, vision and hearing screenings performed by the physician during the preventive health exam.
- This is a grandfathered health plan, as permitted by the Affordable Care Act. Please refer to your employer and your Evidence of Coverage for more information.

## Exclusions From Coverage

- Services or supplies not listed as Covered Services in the Evidence of Coverage (EOC);
- Services or supplies that are determined to be not Medically Necessary and Appropriate;
- Services or supplies that are Investigational;
- Illness or injury resulting from war, that occurred before Your Coverage began under this EOC and that is Covered by: veteran's benefit; or other coverage for which You are legally entitled;
- Self treatment or training;
- Staff consultations required by hospital or other facility rules;
- Services that are free;
- Treatment of work related illness or injury;
- Personal, physical fitness, recreational or convenience items and services, even if ordered by a Practitioner;
- Services or supplies, including those related to a Hospital Confinement, received before Your effective date for Coverage with this Plan;
- Services or supplies received after Your Coverage under this Plan ceases for any reason. This is true even though the expenses relate to a condition that began while You were Covered;
- Services or supplies received in a dental or medical department maintained by or on behalf of the employer, mutual benefit association, labor union or similar group;
- Services or charges to complete a claim form or to provide medical records or other administrative functions;
- Telephone consultations, e-mail or web based consultations or charges for failure to keep a scheduled appointment;
- Court ordered examinations and treatment, unless Medically Necessary;
- Room, board and general nursing care rendered on the date of discharge, unless admission and discharge occur on the same day;
- Benefits for Pre-existing Conditions are excluded until any Pre-existing Condition Waiting Periods have been met;
- Charges in excess of the Maximum Allowable Charge for Covered Services;
- Any service stated in the EOC as a non-Covered Service or limitation;
- Charges for services performed by You or Your spouse, or Your or Your spouse's parent, sister, brother or child;
- Any charges for handling fees;
- Nicotine replacement therapy and aids to smoking cessation including, but not limited to, patches;
- Safety items, or items to affect performance primarily in sports-related activities;
- Services or supplies, including bariatric Surgery, for weight loss or to treat obesity, even if You have other health conditions that might be helped by weight loss or reduction of obesity;
- Services or supplies related to treatment of complications (except Complications of Pregnancy) that are a direct or closely related result of a Member's refusal to accept treatment, medicines, or a course of treatment that a Provider has recommended or has been determined to be Medically Necessary, including leaving an inpatient medical facility against the advice of the treating physician;
- Cosmetic services;
- Blepharoplasty and browplasty;
- Charges relating to surrogate pregnancy, including but not limited to maternity and delivery charges, whether or not the surrogate mother is Covered under the plan;
- Sperm preservation;
- Services or supplies for orthognathic Surgery, a discipline to specifically treat malocclusion. Orthognathic surgery is not surgery to treat cleft palate;
- Maintenance Care;
- Private duty nursing;
- Treatment of sexual dysfunction, regardless of cause;
- Services or supplies related to complications of cosmetic procedures, complications of bariatric Surgery; re-operation of bariatric Surgery or body remodeling after weight loss;
- Cranial orthosis, including helmet or headband, for the treatment of non-synostotic plagiocephaly;
- Chelation therapy, except for control of ventricular arrhythmias or heart block associated with digitalis toxicity; Emergency treatment of hypercalcemia; extreme conditions of metal toxicity, including thalassemia with hemosiderosis; Wilson's disease (hepatolenticular degeneration); and lead poisoning;
- Vagus nerve stimulation for the treatment of depression;
- Balloon sinuplasty for treatment of chronic sinusitis;
- Treatment for benign gynecomastia;
- Treatment for hyperhidrosis;
- Intradiscal annuloplasty to treat discogenic back pain. This procedure provides controlled delivery of heat to the intervertebral disc through an electrode or coil;
- Office visits, physical exams and related immunizations and tests, when required solely for: sports; camp; employment; travel; insurance; marriage or legal proceedings;
- Routine foot care for the treatment of: flat feet; corns; bunions; calluses; toenails; fallen arches; and weak feet or chronic foot strain;
- Dental procedures, except as otherwise indicated in the EOC;
- Inpatient stays primarily for therapy (such as physical or occupational therapy);
- Services that could be provided in a less intensive setting;
- Private room when not Authorized by the Plan and room and board charges are in excess of semi-private room;
- Emergency treatment of a chronic, non-Emergency condition, where the symptoms have existed over a period of time, and a prudent layperson who possesses an average knowledge of health and medicine would not believe it to be an Emergency;
- Ambulance transportation for Your convenience, that is not essential to reduce the probability of harm to You or when You are not transported to a facility;
- Behavioral Health Services except as specified in separate Rider;
- Services or supplies that are designed to create a pregnancy, enhance fertility or improve conception quality;
- Reversals of sterilizations;
- Induced abortion unless: the health care Practitioner certifies in writing that the pregnancy would endanger the life of the mother, or; the fetus is not viable or; the pregnancy is a result of rape or incest, or; the fetus has been diagnosed with a lethal or otherwise significant abnormality;
- Services, supplies or prosthetics primarily to improve appearance;
- Surgeries to correct or repair the results of a prior Surgical Procedure, the primary purpose of which was to improve appearance, even if that prior procedure was a Covered Service;
- Surgeries and related services to change gender (transsexual Surgery);
- Custodial, domiciliary or private duty nursing services;
- Cognitive rehabilitation;
- Therapy/Rehabilitative treatment beyond what can reasonably be expected to significantly improve health, including therapeutic treatments for ongoing maintenance or palliative care;
- Enhancement therapy that is designed to improve Your physical status beyond Your pre-injury or pre-illness state;
- Complementary and alternative therapeutic services, including, but not limited to: massage therapy; acupuncture; craniosacral therapy; cognitive rehabilitation; vision exercise therapy; and neuromuscular reeducation;
- Therapy modalities that do not require the attendance or supervision of a licensed therapist;
- Behavioral therapy, play therapy, communication therapy, and therapy for self correcting language dysfunctions as part of speech therapy, physical therapy or occupational therapy programs;
- Duplicate therapy;
- Organ transplant and related services that did not receive Prior Authorization through transplant case management;
- Transplant related charges in excess of the Transplant Maximum Allowable Charge;
- Donor services including screening and assessment procedures that have not received Prior Authorization;
- Removal of an organ from a Member for purposes of transplantation into another person, except as Covered by the Donor Organ Procurement provision;
- Routine dental care and related services;
- Treatment for correction of underbite, overbite, and misalignment of the teeth;
- Extraction of impacted teeth, including wisdom teeth;
- Diagnostic services that are not Medically Necessary and Appropriate;
- Diagnostic services not ordered by a Practitioner;
- Pharmaceuticals purchased with a prescription except those dispensed at a participating facility, unless listed in a separate rider;
- Pharmaceuticals that may be purchased without a prescription;
- Self-administered Specialty Drugs as identified on the Plan's Specialty Drug list, except as Covered by a supplemental Rider;
- FDA-approved drugs used for purposes other than those approved by the FDA, unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia;
- Services, surgeries and supplies to detect or correct refractive errors of the eyes;
- Eyeglasses, contact lenses and examinations for the fitting of eyeglasses and contact lenses;
- Eye exercises and/or therapy;
- Visual training;
- Charges exceeding the total cost of the Maximum Allowable Charge to purchase Durable Medical Equipment;
- Unnecessary repair, adjustment or replacement or duplicates of any such equipment;
- Supplies and accessories that are not necessary for the effective functioning of the Covered equipment;
- Items to replace those that were lost, damaged, stolen or prescribed as a result of new technology;
- Items that require or are dependent on alteration of home, workplace or transportation vehicle;
- Motorized scooters, exercise equipment, hot tubs, pool, saunas;
- "Deluxe" or "enhanced" equipment;
- Computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, and seat lifts of any kind;
- Patient lifts, auto tilt chairs, air fluidized beds, or air flotation beds, unless approved by Case Management for a Member who is in Case Management;
- Portable ramp for a wheelchair;
- Non-wearable external defibrillator;
- Diabetic treatments or supplies that are not prescribed and certified by a Practitioner as being Medically Necessary;
- Diabetic supplies not required by state statute;
- Prosthetics primarily for cosmetic purposes, including but not limited to wigs, or other hair prostheses or transplants;
- Replacements of contacts after the initial pair have been provided following cataract Surgery;
- Foot orthotics, shoe inserts and custom made shoes except as required by law for diabetic patients or as a part of a leg brace;
- Items such as non-treatment services or: routine transportation; homemaker or housekeeping services; behavioral counseling; supportive environmental equipment; Maintenance Care or Custodial Care; social casework; meal delivery; personal hygiene; and convenience items;
- Services such as: homemaker or housekeeping services; meals; convenience or comfort items not related to the illness; supportive environmental equipment; private duty nursing; routine transportation; and funeral or financial counseling;
- Supplies that can be obtained without a prescription (except for diabetic supplies).

Please refer to the Evidence of Coverage for Complete description of benefits and exclusions.

## **\$10/\$25/\$50 Prescription Drug Plan**

## **\$20/\$50/\$100 Specialty Drug Plan**

<b>Prescription Contraceptive Drugs</b>	<b>100% coverage per prescription, up to 30 day supply</b>
<b>Generic Drugs</b>	<b>\$10 Copay per prescription, up to 30 day supply</b>
<b>Preferred Brand Name Drugs</b>	<b>\$25 Copay per prescription, up to 30 day supply</b>
<b>Non-preferred Brand Name Drugs</b>	<b>\$50 Copay per prescription, up to 30 day supply</b>

The copayment is the amount you pay to a network pharmacy for each prescription you have filled. Your copayment is dependent upon which brand level of drug you choose.

### **Prescription Contraceptive Drug**

In accordance with the Women's Preventive Services provision of the Affordable Care Act, BlueCross BlueShield of Tennessee offers access to prescription contraceptive drugs to eligible members at no cost when filled by in-network pharmacies.

Drugs on the Prescription Contraceptive Drug list include: prescription generic oral and injectable contraceptives, vaginal ring and hormonal patch. Other brand-name prescription contraceptives will be covered subject to cost share under this prescription drug rider. See the Prescription Contraceptive Drug list for complete list of covered drugs.

### **Generic Drugs- your copay is \$10**

Generic drugs offer the best value. A generic drug is a safe and effective alternative to a brand name drug. You pay the lowest copay when you choose a generic drug. When your doctor writes your prescription, ask about using a generic drug.

Generic drugs are made with the same active ingredients and produce the same effects in the body as their brand-name equivalents. The difference? Just the name and price -- and generics cost less. BlueCross BlueShield of Tennessee encourages the use of generic drugs by offering lower copayments when choosing generics.

### **Preferred Brand Drugs- your copay is \$25**

The Preferred Drug List is a list of therapeutically sound, cost-effective drugs, and is provided to encourage the use of certain drugs within a therapeutic class. When your doctor prescribes a preferred brand drug, your copay is \$25. But if you receive a brand-name drug when a generic equivalent is available, you must pay the generic copay plus the cost difference between the brand-name drug and generic drug.

### **Non-Preferred Brand Drugs- your copay is \$50**

When your doctor prescribes a brand drug that is not on the Preferred Drug list, you pay the highest copay of \$50. But if you receive a brand-name drug when a generic equivalent is available, you must pay the generic copay plus the cost difference between the brand-name drug and generic drug.

### **Pricing at Participating Pharmacies**

When a member receives a prescription at a pharmacy, he or she typically pays the appropriate copayment (either generic or brand under a two-tier plan; or generic, preferred brand or non-preferred brand under a three-tier plan). Members pay less than the copayment if the pharmacy's usual price for the drug is less than the copayment.

### **Choosing a Brand when a Generic Equivalent is Available**

You'll always save money when using generics. In fact, all you pay is the generic copay. But if you receive a brand-name drug when a generic equivalent is available, you must pay the generic copay plus the cost difference between the brand-name drug and generic drug.

**Limitations**

**These limitations apply to each prescription order.**

Benefits will be provided for

- up to a 30-calendar-day supply of prescription drugs, and/or
- up to a 90-calendar-day supply of prescription drugs obtained through Prescription Home Delivery or the Home Delivery Retail Network.

Some drugs require prior authorization, step therapy or have quantity limitations. Please refer to the special drug lists on the pharmacy page on [www.bcbst.com](http://www.bcbst.com) for more information.

### **Step Therapy**

Step Therapy is a form of Prior Authorization. When Step Therapy is required, You must initially try a drug that has been proven effective for most people with Your condition. This initial drug will be a Covered Generic Drug (if available) or a Preferred Brand Drug.

However, if You have already tried an alternate, less expensive drug and it did not work, or if Your doctor believes that You must take the more expensive drug because of Your medical condition, Your doctor can contact the Plan to request an exception. If the request is approved, the Plan will cover the requested drug.

### **Refills**

Refills must be dispensed pursuant to a Prescription. If the number of refills is not specified in the Prescription, benefits for refills will not be provided beyond one year from the date of the original prescription.

The Plan has time limits on how soon a Prescription can be refilled. If you request a refill too soon, the Network Pharmacy will advise you when your Prescription benefit will cover the refill.

### **Prescription Home Delivery**

Enjoy the convenience of prescription home delivery. Simply mail a completed form along with the written prescription and payment in one of the envelopes provided or visit the pharmacy section at [www.bcbst.com](http://www.bcbst.com) for other helpful ways to have your prescriptions delivered to your home or another preferred address.

### **Home Delivery Retail Network**

Another convenient way to obtain up to a 90-calendar-day supply of drugs is through the Home Delivery Retail network. The Home Delivery Retail Network is a network of retail pharmacies that are permitted to dispense prescription drugs to BlueCross BlueShield of Tennessee members on the same terms as pharmacies in the Home Delivery Network. A directory of the participating Home Delivery Retail Network is available online at [www.bcbst.com](http://www.bcbst.com).

### **Out-of-Network Pharmacies**

If a prescription is filled at an out-of-network pharmacy, you must pay all costs. A claim can then be submitted to BlueCross BlueShield of Tennessee. Reimbursement is based on the BlueCross BlueShield of Tennessee allowed charge, less any applicable copay, deductible or coinsurance amount.

### **A Broad Network of Retail Pharmacies**

BlueCross BlueShield of Tennessee members access the Caremark network for retail pharmacy benefits. Your pharmacy network provides tremendous accessibility in Tennessee as well as nationally. A directory of participating pharmacies is available online at [www.bcbst.com](http://www.bcbst.com). Click on Find a Pharmacy, and enter the pharmacy network code that appears in the bottom center of your BlueCross BlueShield of Tennessee ID card. This code will start with RX (RX04, for example).

### **Self-Administered Specialty Pharmacy Network and Coverage**

You have a separate network for Specialty Drugs: the Specialty Pharmacy Network. You receive the highest level of benefits when you use a Specialty Pharmacy Network provider for your self-administered Specialty Drugs. **Accredo Health Group, Caremark Specialty Pharmacy Services, CuraScript, Inc., and Walgreens Specialty Pharmacy** are experienced in managing high-cost drugs and providing patient support for complex conditions such as Hepatitis C, Multiple Sclerosis, Arthritis and Hemophilia.



Accredo Health Group	Caremark Specialty Pharmacy Services	CuraScript, Inc.	Walgreens Specialty Pharmacy
1-888-239-0725 (phone) 1-866-387-1003 (fax)	1-800-237-2767 (phone) 1-800-323-2445 (fax)	1-888-773-7376 (phone) 1-888-773-7386 (fax)	1-888-347-3416 (phone) 1-877-231-8302 (fax)

You may purchase self-administered Specialty Drugs from a retail pharmacy, but your copay will be higher. When purchasing self-administered Specialty Drugs from an Out-of-Network Pharmacy, you must pay all expenses and file a claim for reimbursement with us. You will be reimbursed based on the Maximum Allowable Charge, less any applicable Drug Copayment amount.

Please refer to the Specialty Drug List to see which drugs are covered as self-administered specialty Drugs. Go to [www.bcbst.com/Pharmacy](http://www.bcbst.com/Pharmacy).

**Specialty Drugs are limited to a 30-day supply per Prescription.**

	Specialty Pharmacy Network	Other Network Pharmacies	Out-of-Network Pharmacies
A Self-Administered Specialty Drug, as indicated on Our Specialty Drug list.	\$100 Drug Copayment per Prescription	\$200 Drug Copayment per Prescription	You pay all costs, then file a claim for reimbursement. You will be reimbursed based on the Maximum Allowable Charge, less any applicable Drug Copayment amount.
If a drug that is on Our Specialty Drug list is also a Generic Drug or a Preferred Brand Drug, then Your Copayment will be:			
A Generic Drug that is also a Self-Administered Specialty Drug, as indicated on Our Specialty Drug list.	\$20 Drug Copayment per Prescription	\$40 Drug Copayment per Prescription	You pay all costs, then file a claim for reimbursement. You will be reimbursed based on the Maximum Allowable Charge, less any applicable Drug Copayment amount.
A Preferred Brand Drug that is also a Self-Administered Specialty Drug, as indicated on Our Specialty Drug list.	\$50 Drug Copayment per Prescription	\$100 Drug Copayment per Prescription	You pay all costs, then file a claim for reimbursement. You will be reimbursed based on the Maximum Allowable Charge, less any applicable Drug Copayment amount.

(Please refer to Your EOC for information on benefits for provider-administered Specialty Drugs, which are covered as a Medical benefit.)

**Need More Information?**

For more information on prescription drug coverage or our pharmacy programs call 1-800-565-9140. You can also visit the pharmacy section at [www.bcbst.com](http://www.bcbst.com).

***Benefits will not be provided for:***

- drugs for the treatment of onychomycosis (e.g., nail fungus), except for: 1) diabetics; or 2) immunocompromised patients.
- Growth Hormone Replacement Therapy is not Covered, except for: (1) treatment of absolute growth hormone deficiency in children whose epiphyses have not closed and who at initiation of therapy had a height of more than 2 standard deviations below the mean for chronological age; (2) growth hormone replacement therapy prior to renal transplant in children whose epiphyses have not closed and who also have chronic renal insufficiency (glomerular filtration rate GFR less than 60ml/minute/1.73 meter squared); (3) Members diagnosed with Turner syndrome; (4) Members diagnosed with Noonan Syndrome; (5) Members diagnosed with Prader-Willi syndrome and confirmed by appropriate genetic testing; (6) Members with decreased hypothalamic function due to any of the following reasons: pituitary tumor, pituitary surgical damage, trauma or cranial irradiation; or (7) Members under age 18 diagnosed with pituitary dwarfism.;
- prescription and non-prescription medical supplies, devices and appliances, except for syringes used in conjunction with injectable medications or other supplies used in the treatment of diabetes and/or asthma;
- immunizations or immunological agents, including but not limited to: 1) biological sera, 2) blood, 3) blood plasma; or 4) other blood products are not Covered, except for blood products required by hemophiliacs.
- injectable drugs, unless: 1) intended for self-administration; or 2) defined by the Plan.
- drugs which are prescribed, dispensed or intended for use while You are confined in a hospital, skilled nursing facility or similar facility, except as otherwise Covered in the EOC;
- any drugs, medications, Prescription devices or vitamins, available over-the-counter that do not require a Prescription by Federal or State law; except as otherwise Covered in the EOC;
- any quantity of Prescription Drugs which exceeds that specified by the Plan's P & T Committee;
- any Prescription Drug purchased outside the United States, except those authorized by Us;
- any Prescription dispensed by or through a non-retail internet Pharmacy;
- contraceptives which require administration or insertion by a Provider (e.g., non-drug devices, implantable products such as Norplant, except injectables), except as otherwise Covered in the EOC;
- medications intended to terminate a pregnancy (e.g., RU-486);
- non-medical supplies or substances, including support garments, regardless of their intended use;
- artificial appliances;
- allergen extracts;
- any drugs or medicines dispensed more than one year following the date of the Prescription;
- Prescription Drugs You are entitled to receive without charge in accordance with any worker's compensation laws or any municipal, state, or federal program;
- replacement Prescriptions resulting from lost, spilled, stolen, or misplaced medications (except as required by applicable law);
- drugs dispensed by a Provider other than a Pharmacy;
- administration or injection of any drugs;
- Prescription Drugs used for the treatment of infertility;
- Prescription Drugs not on the Drug Formulary;
- anorectics (any drug or medicine for the purpose of weight loss and appetite suppression);
- nicotine replacement therapy and aids to smoking cessation including, but not limited to, patches;
- all newly FDA approved drugs prior to review by the Plan's P & T Committee. Prescription Drugs that represent an advance over available therapy according to the P & T Committee will be reviewed within at least six (6) months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug, will be reviewed within at least twelve (12) months after FDA approval;
- any Prescription Drugs or medications used for the treatment of sexual dysfunction, including but not limited to erectile dysfunction (e.g. Viagra), delayed ejaculation, anorgasmia and decreased libido;
- Prescription Drugs used for cosmetic purposes including, but not limited to: 1) drugs used to reduce wrinkles (e.g. Renova); 2) drugs to promote hair-growth; 3) drugs used to control perspiration; 4) drugs to remove hair (e.g. Vaniqa); and 5) fade cream products;
- Prescription Drugs used during the maintenance phase of chemical dependency treatment, unless Authorized by Us;
- FDA approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia;
- Compound drugs filled or refilled at an Out-of-Network Pharmacy;
- drugs used to enhance athletic performance;
- Experimental and/or Investigational Drugs;
- Provider-administered Specialty Drugs, as indicated on Our Specialty Drug list; and
- Prescription Drugs or refills dispensed:
  - in quantities in excess of amounts specified in the BENEFIT PAYMENT section;
  - without Our Prior Authorization when required; or
  - which exceed any applicable Annual Maximum Benefit, or any other maximum benefit amounts stated in this Rider or the EOC



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These exclusions only apply to this Rider. Items that are excluded under the Rider may be Covered as medical supplies under the EOC. Please review your EOC carefully.

## Behavioral Health Benefits - Option 1 and 2 Mental Health/Substance Abuse Treatment

### Benefits

	In-Network	Out-of-Network
Inpatient Services	80% after Deductible	60% after Deductible
Outpatient Services	\$20 Copay	60% after Deductible

### Prior Authorization Requirements

Prior Authorization is required for:

- All inpatient levels of care. Inpatient levels of care include: Acute care, residential care, partial hospital and intensive outpatient programs.
- Electro-convulsive therapy (ECT) provided on an inpatient or outpatient basis.
- Outpatient visits do not require Prior Authorization.

***When an out-of-network provider is used and prior authorization is not obtained and the service is determined to be medically necessary, benefits will be provided at 50% of the maximum allowable charge after the deductible. Benefits will not be provided if the services are determined to be not medically necessary.***

### Emergency Care

In an emergency, go to the nearest network facility or to the emergency room of the closest medical hospital. An emergency admission to the hospital does not need prior authorization, but you or the hospital must call Behavioral Health Services within 24 hours.

### Access To Services

If you or a covered family member needs help, call the Behavioral Health Services Help Line phone number listed on the back of your BlueCross Blue Shield of Tennessee ID card. **This toll-free number offers assistance 24 hours a day, seven days a week, 365 days a year.**

For inpatient referral and inpatient prior authorization please call the telephone number on the back of your ID card and a care manager will direct you to a participating provider. Consult your directory to determine whether a particular provider is in the network. If you choose to use providers who are not in the behavioral health network, your benefits may be reduced. Behavioral health providers include experienced professionals, programs, and facilities to meet your needs. Any information you provide will be confidential.

If you are outside the State of Tennessee and need behavioral health care you must:

- For Inpatient care, have the hospital call Behavioral Health Services within 24 hours.
- To determine the network status of a provider in the state in which you wish to seek care, call the Behavioral Health Services number on the back of your ID card and ask to speak with a BlueCross BlueShield of Tennessee customer service representative. This call should be made between the hours of 8:30 a.m. and 5:30 p.m. EST, Monday through Friday.

## Behavioral Health Benefits - Option 3 Mental Health/Substance Abuse Treatment

### Benefits

	In-Network	Out-of-Network
Inpatient Services	90% after Deductible	70% after Deductible
Outpatient Services	\$20 Copay	70% after Deductible

### Prior Authorization Requirements

Prior Authorization is required for:

- All inpatient levels of care. Inpatient levels of care include: Acute care, residential care, partial hospital and intensive outpatient programs.
- Electro-convulsive therapy (ECT) provided on an inpatient or outpatient basis.
- Outpatient visits do not require Prior Authorization.

***When an out-of-network provider is used and prior authorization is not obtained and the service is determined to be medically necessary, benefits will be provided at 50% of the maximum allowable charge after the deductible. Benefits will not be provided if the services are determined to be not medically necessary.***

### Emergency Care

In an emergency, go to the nearest network facility or to the emergency room of the closest medical hospital. An emergency admission to the hospital does not need prior authorization, but you or the hospital must call Behavioral Health Services within 24 hours.

### Access To Services

If you or a covered family member needs help, call the Behavioral Health Services Help Line phone number listed on the back of your BlueCross Blue Shield of Tennessee ID card. **This toll-free number offers assistance 24 hours a day, seven days a week, 365 days a year.**

For inpatient referral and inpatient prior authorization please call the telephone number on the back of your ID card and a care manager will direct you to a participating provider. Consult your directory to determine whether a particular provider is in the network. If you choose to use providers who are not in the behavioral health network, your benefits may be reduced. Behavioral health providers include experienced professionals, programs, and facilities to meet your needs. Any information you provide will be confidential.

If you are outside the State of Tennessee and need behavioral health care you must:

- For Inpatient care, have the hospital call Behavioral Health Services within 24 hours.
- To determine the network status of a provider in the state in which you wish to seek care, call the Behavioral Health Services number on the back of your ID card and ask to speak with a BlueCross BlueShield of Tennessee customer service representative. This call should be made between the hours of 8:30 a.m. and 5:30 p.m. EST, Monday through Friday.



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## Preventive 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 (NuvaRing), 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



## Vision Care 2

With these benefits, you may visit any vision care provider for a routine eye exam once every annual benefit period.

Because some vision providers will not file your claim, be prepared to pay in full, up front. After you file your claim, BlueCross BlueShield of Tennessee will reimburse you for the covered amount, minus your copayment, up to the maximum allowable charge. If the provider charges more than the maximum allowable charge for glasses or contacts, you will pay the excess. You will not pay more than \$20 for the vision exam.

### Vision Benefits

1 vision exam per annual benefit period	\$20 Copay
1 set of lenses (including bifocal, trifocal) per annual benefit period	100% up to \$85
Contact lenses in lieu of eyeglasses per annual benefit period	100% up to \$150
1 set of frames every 2 annual benefit periods	100% up to \$75

### Exclusions:

Benefits will not be provided for the following services, supplies or charges:

- Charges for vision testing examinations, lenses and frames ordered while insured but not delivered within 60 days after Coverage is terminated.
- Charges for sunglasses, photosensitive, anti-reflective or other optional charges when the charge exceeds the amount allowable for regular lenses.
- Charges filed for procedures determined by the Plan to be special or unusual, (i.e. orthoptics, vision training, subnormal vision aids, aniseikonic lenses, tonography, corneal refractive therapy, etc.)
- Charges for lenses that do not meet the Z80.1 or Z80.2 standards of the American National Standards Institute.
- Charges in excess of the Maximum Allowable Charge as established by the Plan.
- Charges for non-prescription lenses.