of Tennessee

City of Memphis

Effective Date: 1/1/2022

Network: S

Benefit Summary

Option: Select Plan w/HRA

Health Reimbursement Arrangement (HRA)	Individual	Family
HRA Allocation [23]	$750	$1500
HRA Covers	Medical and Pharmacy Expenses	
HRA Eligible Expenses	Deductible/Coinsurance/Copay	
HRA Reimbursement Order	HRA Pays First - The HRA reimburses first, then the employee pays his/her share.	
HRA Reimbursement Percentage	100%	

Benefit Plan Features:	Your Cost In-Network at Baptist, LeBonheur, Regional One & St. Francis	Your Cost Out-of-Network [1]
Annual Deductible		
Individual/Family	$1,500 / $3,000	$3,000 / $6,000
Annual Out-of-Pocket Maximum (includes copay, coinsurance and deductibles)		
Individual/Family	$5,000 / $10,000	$10,000 / $20,000
4th Quarter Carry-over	Excluded	
Covered Services		
Preventive Care Services (see page 3 for a list)	Covered at 100%	Not Covered
Practitioner Office Services		
Primary Care Office Visits [21]	$15 copay	50% after deductible
Specialist Office Visits	20% after deductible	50% after deductible
Office Surgery [3, 4, 6, 21]	20% after deductible	50% after deductible
Routine Diagnostic Lab, X-Ray & Injections	No Additional Copay	50% after deductible
Advanced Radiological Imaging [2, 4, 7]	20% after deductible	50% after deductible
Provider-Administered Specialty Drugs [3]	$15 PCP office visit copay or Specialist office visit 20% after deductible	50% after deductible
PhysicianNow® Powered by MDLIVE [18]	$0 copay	Not Covered
Services Received at a Facility (includes professional and facility charges)		
Inpatient Services [2, 4]	20% after deductible	50% after deductible
Outpatient Surgery [3, 4, 6]	20% after deductible	50% after deductible
Routine Diagnostic Services - Outpatient	Covered at 100%	50% after deductible
Advanced Radiological Imaging - Outpatient [2, 4, 7]	20% after deductible	50% after deductible
Other Outpatient Services [8]	20% after deductible	50% after deductible
Urgent Care Center Services	20% after deductible	50% after deductible
Emergency Care Services [9, 10]	$300 copay then 20% after deductible (copay waived if admitted to the hospital)	$300 copay then 20% after deductible (copay waived if admitted to the hospital)
Emergency Care Advanced Radiological Imaging [7, 10]	20% after deductible	20% after deductible
Medical Equipment Services [3, 4]		
Durable Medical Equipment	20% after deductible	50% after deductible
Prosthetic or Orthotics	20% after deductible	50% after deductible
Hearing Aids (under age 18)	20% after deductible	50% after deductible
Behavioral Health Services		
Inpatient: Unlimited days per annual benefit period [2, 4]	20% after deductible	50% after deductible
Outpatient: Unlimited Office visits per annual benefit period [5]	$0 office visit copay visit 1-10. $10 office visit copay starts visit 11.	50% after deductible
Therapeutic Services [11] (limits apply; see footnote)	$30 copay	50% after deductible
Skilled Nursing & Rehabilitation Facility Services [2, 4]		
Limited to 70 days combined per annual benefit period	20% after deductible	50% after deductible

Home Health Care Services [3, 4, 11]	20% after deductible	50% after deductible
Hospice Services		
Inpatient [2, 4]	20% after deductible	50% after deductible
Outpatient	20% after deductible	50% after deductible
Ambulance Services [3, 4]	20% after deductible	20% after deductible
Prescription Drugs [3]		
Prescription Contraceptives [17]	Covered at 100%	Not Covered
***Prescription deductible applies to preferred, non-preferred and specialty brand drugs.**		
Retail RX04 Network up to 30 day supply		
Generic [14]	$7 copay	50% after deductible
Preferred [14, 16]	Deductible then $30 copay	50% after deductible
Non-Preferred [14, 16]	20% after deductible is met with a $50 min and a max of $100	50% after deductible
Plus90 or Home Delivery Network up to 90 day supply		
Generic [15]	$14 copay	50% after deductible
Preferred [15, 16]	Deductible then $60 copay	50% after deductible
Non-Preferred [15, 16]	20% after deductible is met with a $50 min and a max of $100	50% after deductible
Self-Administered Specialty Drugs [3, 12, 13]		
Generic [15]	$7 copay	Not Covered
Preferred [15, 16]	Deductible then $30 copay	Not Covered
Non-Preferred [15, 16]	Deductible then 20% with a $50 min and a max of $100	Not Covered

Notes:

1. Out-of-network benefit payment based on BlueCross BlueShield of Tennessee maximum allowable charge. You are responsible for any unpaid billed charges.
2. Prior authorization is required.
3. Certain procedures, services, medication and equipment may require prior authorization.
4. If prior authorization is required but not obtained and services are medically necessary, when using network providers outside Tennessee for physician and outpatient services and all services from out-of-network providers, your liability will be increased by 10% based on out-of-network coinsurance. If services are not medically necessary, no benefits will be provided.
5. Outpatient behavioral health benefits are determined by place of service. Benefits displayed are for services received in an office setting; separate benefits may apply for outpatient services received in an alternate setting.
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 for non-preventive purposes).
7. Includes CT scans, PET scans, MRIs, nuclear medicine and other similar technologies.
8. Includes services such as chemotherapy, infusions, injections, radiation therapy and renal dialysis.
9. Copay, if applicable, waived if admitted to hospital.
10. In true emergency situations, out-of-network emergency services apply to the in-network deductible and/or out-of-pocket maximum.
11. Physical, speech, pulmonary rehabilitative and occupational therapies are limited to 60 combined visits per annual benefit period. Cardiac rehabilitative therapy limited to 36 visits per annual benefit period. Acupuncture and spinal manipulative limited to 20 visits per therapy type per annual benefit period.
    *__Spinal manipulative is not covered out-of-network.__
12. Visit www.bcbst.com/rx for the Preferred Formulary which includes specialty drugs.
13. You have a distinct arrangement for self-administered specialty drugs. To receive benefits, you must use a Specialty Pharmacy Network provider. Visit www.bcbst.com/rx for a list of providers in the Specialty Pharmacy Network. Specialty drugs are limited to a 30-day supply.
14. Copay, if applicable, applied per prescription, up to a 30 day supply.
15. 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 www.bcbst.com/rx to find a list of pharmacies in the Plus90 Network.
16. 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.
17. Certain prescription drugs are covered at 100% at network pharmacies, in accordance with the Preventive Services provision of the Affordable Care Act, and are identified on the drug formulary with an "ACA" indicator. Visit www.bcbst.com/rx for the Preferred Formulary.
18. Speak to a board-certified doctor for certain non-emergency conditions day or night over the phone or using secure online video. Or schedule a visit for counseling services in advance. Visit www.bcbst.com/physiciannow or call 1-888-283-6691 to register.
21. The lower copay applies to Family Practice, General Practice, Internal Medicine, OB/GYN, Pediatrics, Behavioral Health and Health Department services. The copay for Physician Assistants or Nurse Practitioners may be based on the provider type of the billing provider.
23. HRA Plan: Your HRA allocation is shared, which means one individual or a combination of covered individuals in a family plan may satisfy or use the entire amount noted in the family tier. If your BlueCross HRA becomes effective in a month other than January, your annual allocation may be prorated.
24. To receive benefits for provider-administered specialty drugs as identified on the provider-administered specialty drug list, you must use a provider in our preferred specialty pharmacy network. Visit www.bcbst.com/rx for the drug list and a list of Cost share listed is for the medication only; providers may bill additional charges for the administering of the drug under your medical benefit.

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.

Summary of Preventive Care Services Covered at 100% In-Network

In-network preventive care services that are covered with no member cost share include, but are not limited to:

- 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 (not an all-inclusive list). Coverage of some services may depend on age and/or risk exposure.

All Members:

- One preventive health exam per annual benefit period. 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 (45 and older for women; 35 and older for men), high blood pressure, obesity, diabetes, and depression (12 and older)
- Screening for lung cancer for adults (55 to 80) who have a 30 pack-year smoking history and either currently smoke or have quit within the past 15 years, per annual benefit period
- Screening for HIV and certain sexually transmitted diseases, and counseling for the prevention of sexually transmitted diseases
- Screening and counseling in a primary care setting for alcohol misuse and tobacco use; alcohol misuse and tobacco use limited to 8 visits per annual benefit period
- Dietary counseling for adults with hyperlipidemia, hypertension, type 2 diabetes, obesity, coronary artery disease and congestive heart failure; limited to 12 visits per annual benefit period
- One retinopathy screening for diabetics per annual benefit period
- Hemoglobin A1C testing

Women:

- Well-woman visit, including annual sexually transmitted infection (STI) counseling and annual domestic violence screening & counseling per annual benefit period
- Cervical Cancer Screening per annual benefit period
- Screening of pregnant women for anemia, iron deficiency, bacteriuria, hepatitis B virus, Rh factor incompatibility, gestational diabetes
- Breastfeeding support/counseling & supplies, including lactation support and counseling by a trained provider and one manual breast pump per pregnancy
- Counseling for women at high risk of breast cancer for chemoprevention, including risks and benefits
- Mammography screening at age 40 and over, and genetic counseling and, if indicated after counseling, BRCA testing for BRCA breast cancer gene
- Osteoporosis screening (age 60 or older)
- HPV testing once every 3 years, beginning at age 30
- 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
- One-time 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

BlueCross BlueShield of Tennessee (BlueCross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BlueCross does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

BlueCross:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified interpreters and (2) written information in other formats, such as large print, audio and accessible electronic formats.
- Provides free language services to people whose primary language is not English, such as: (1) qualified interpreters and (2) written information in other languages.

If you need these services, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711).

If you believe that BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance ("Nondiscrimination Grievance"). For help with preparing and submitting your Nondiscrimination Grievance, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711). They can provide you with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address your Nondiscrimination Grievance to: Nondiscrimination Compliance Coordinator; c/o Manager, Operations, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; (423) 591-9208 (fax); Nondiscrimination_OfficeGM@bcbst.com (email).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–368–1019, 800–537–7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association.

BlueCross BlueShield of Tennessee is a Qualified Health Plan Issuer in the Health Insurance Marketplace.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-565-9140 (TTY: 1-800-848-0298).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-565-9140 (رقم هاتف الصم والبكم: 1-800-848-0298).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-565-9140 (TTY:1-800-848-0298)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-565-9140 (TTY:1-800-848-0298).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-565-9140 (TTY: 1-800-848-0298) 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-565-9140 (ATS : 1-800-848-0298).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-565-9140 (TTY: 1-800-848-0298).

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-565-9140 (መስማት ለተሳናቸው: 1-800-848-0298).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-565-9140 (TTY: 1-800-848-0298).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-565-9140 (TTY:1-800-848-0298)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-565-9140 (TTY:1-800-848-0298) まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-565-9140 (TTY:1-800-848-0298).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-565-9140 (TTY:1-800-848-0298) पर कॉल करें।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-565-9140 (телетайп: 1-800-848-0298).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-565-9140 (TTY:1-800-848-0298) تماس بگیرید.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-565-9140 (TTY: 1-800-848-0298).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-565-9140 (TTY: 1-800-848-0298).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-565-9140 (TTY: 1-800-848-0298).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-565-9140 (TTY: 1-800-848-0298).

Dii baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, kojí' hódíílnih 1-800-565-9140 (TTY: 1-800-848-0298).