

City of Memphis

Effective Date: Jan 1, 2025

	Benefit Summary	Select Plan w/HRA
ealth Reimbursement Arrangement (HRA)	Individual	Family
RA Allocation 22	\$750	\$1500
RA Covers	Medical	and Pharmacy Expenses
RA Eligible Expenses	Deductible/Coinsurance/Copay	
RA Reimbursement Order	HRA Pays First - The HRA reimburses first,	
IDA Deimhurgement Dereentage	then the employee pays his/her share 100%	
IRA Reimbursement Percentage	Your Cost In-Network	100 %
Benefit Plan Features:	LeBonheur, Regional One & St. Francis	Your Cost Out-of-Network <sup>1</sup>
nnual Deductible		
ndividual/Family	\$1,500 / \$3,000	\$3,000 / \$6,000
Annual Out-of-Pocket Maximum		
(includes copay, coinsurance and deductibles)		
ndividual/Family	\$5,000 / \$10,000	\$10,000 / \$20,000 Excluded
th Quarter Carry-over covered Services		Excluded
reventive Care Services (see page 3 for a list)	Covered at 100%	Not Covered
ractitioner Office Services	Covered at 100 %	Not Covered
Primary Care Office Visits <sup>20</sup>	\$15 copay	50% after deductible
Specialist Office Visits	\$30 copay	50% after deductible
Office Surgery <sup>3, 4, 6, 20</sup>	20% after deductible	50% after deductible
Diffice Surgery - Specialist 3, 4, 6, 20	\$30 copay	50% after deductible
Routine Diagnostic Lab, X-Ray & Injections	20% after deductible	50% after deductible
Advanced Radiological Imaging <sup>2, 4, 7</sup>	20% after deductible	50% after deductible
Provider-Administered Specialty Drugs <sup>3, 23</sup>	20% after deductible	Not Covered
eladoc <sup>™</sup> Health Virtual Care <sup>17</sup>	\$0 copay	Not Covered
Services Received at a Facility	¢¢ sopay	
(includes professional and facility charges)		
npatient Services <sup>2,4</sup>	20% after deductible	50% after deductible
Dutpatient Surgery <sup>3, 4, 6</sup>	20% after deductible	50% after deductible
Routine Diagnostic Services - Outpatient	20% after deductible	50% after deductible
Advanced Radiological Imaging - Outpatient <sup>2, 4, 7</sup>	20% after deductible	50% after deductible
Dther Outpatient Services <sup>8</sup>	20% after deductible	50% after deductible
Jrgent Care Center Services	\$75 copay	50% after deductible
	\$300 copay then 20% after deductible	\$300 copay then 20% after deductible
Emergency Care Services <sup>9</sup>	(copay waived if admitted to the hospital)	(copay waived if admitted to the hospital)
Emergency Care Advanced Radiological Imaging <sup>7</sup>	20% after deductible	20% after deductible
Aedical Equipment Services <sup>3, 4</sup>		
Durable Medical Equipment	20% after deductible	50% after deductible
Prosthetic or Orthotics	20% after deductible	50% after deductible
learing Aids (under age 18)	20% after deductible	50% after deductible
Behavioral Health Services		
npatient: Unlimited days per annual benefit period <sup>2, 4</sup>	20% after deductible	50% after deductible
	\$0 office visit copay visit 1-10	50% after deductible
Dutpatient: Unlimited visits per annual benefit period $^{\circ}$	\$10 office visit copay starts visit 11	
herapeutic Services <sup>10</sup> (limits apply; see footnote)	\$30 copay	50% after deductible
killed Nursing & Rehabilitation Facility Services <sup>2, 4</sup>		
imited to 70 days combined per annual benefit period	20% after deductible	50% after deductible
lome Health Care Services <sup>3, 4, 10</sup>	20% after deductible	50% after deductible
lospice Services		
npatient <sup>2,4</sup>	20% after deductible	50% after deductible
Dutpatient	20% after deductible	50% after deductible
Imbulance Services <sup>3, 4</sup>	20% after deductible	20% after deductible
Prescription Drugs <sup>3</sup>		<u> </u>
\$250 brand drug deductible applies to preferred and non-pref		ļ
rescription Contraceptives <sup>16</sup>	Covered at 100%	Not Covered
Retail RX03 Network up to 30 day supply <sup>13</sup>		
Preferred Generic	\$7 copay	50% after deductible
Preferred Brand <sup>15</sup>	\$30 copay after deductible	50% after deductible
Non-Preferred Brand <sup>15</sup>	20% after deductible is met with a \$50	50% after deductible
	min and a max of \$100	
Plus90 or Home Delivery Network up to 90 day supply <sup>14</sup>		
Preferred Generic	\$14 copay	50% after deductible
Preferred Brand <sup>15</sup>	\$60 copay after deductible	50% after deductible
Non-Preferred Brand <sup>15</sup>	20% after deductible is met with a \$100	50% after deductible
	min and a max of \$200	
Self-Administered Specialty Drugs <sup>3, 11, 12</sup>	\$20 sonou ofter do to the	Not Course d
Preferred Specialty Drugs	\$30 copay after deductible Deductible then 20% with a \$50 min	Not Covered

1. Out-of-network benefits may be based on BlueCross BlueShield of Tennessee maximum allowable charge. You may be responsible		
for any unpaid billed charges for certain services received from out-of-network providers. For emergency care services received at		
an out-of-network facility, covered items and services received from an out-of-network provider at an in-network facility (unless you give		
certain providers written consent), or emergent and authorized air ambulance services, in-network benefits including deductible will		
apply up to the qualified payment amount, and the provider may not bill you for more than your in-network cost share.		
2. Prior authorization is required.		
3. Certain procedures, services, medication and equipment may require prior authorization.		
<ol><li>If prior authorization is required but not obtained and services are medically necessary, when using network providers outside</li></ol>		
Tennessee for physician and outpatient services and all services from out-of-network providers, your liability will be increased		
to 60% 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.		
<ol><li>Surgeries include incisions, excisions, biopsies, injection treatments, fracture treatments, applications of casts and splints,</li></ol>		
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.		
<ol><li>Includes services such as chemotherapy, infusions, injections, radiation therapy and renal dialysis.</li></ol>		
9. Copay, if applicable, waived if admitted to hospital.		
10. 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		
11. Visit www.bcbst.com/rx for the Preferred Formulary which includes specialty drugs.		
12. You must use one of the Specialty Pharmacy Network providers listed on www.bcbst.com/rx to receive benefits for self-		
administered specialty drugs, and these drugs are limited to a 30-day supply.		
13. Copay, if applicable, applied per prescription, up to a 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 www.bcbst.com/rx 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 Summary Plan Description (SPD) for specific information.		
16. 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 with an "ACA" indicator on the Preferred Formulary located at www.bcbst.com/rx.		
17. Use Teladoc's virtual care platform to access doctors or professionals for 24/7 urgent care, mental health care, dermatology services,		
and more. Visit www.bcbst.com/physiciannow or call 1-888-283-6691 to register.		
20. 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.		
22. 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.		
23. To receive benefits for provider-administered speciality drugs as identified on the provider-administered speciality drug list, you must		
use a Specially Pharmacy Network provider. Visit www.bcbst.com/rx for the drug list and a list of providers in this network. Cost		
share listed is for the medication only; providers may bill additional charges for the administering of the drug under your medical benefit.		
****Fertility treatment (All Services covered with a \$30,000 (\$15,000 medical / \$15,000 pharmacy) Lifetime maximum benefit.		
Limitations and Exclusions. These pages summarize your health care plan benefits. Your Summary Plan Description (SPD) defines the full		
terms and conditions, limitations, and exclusions in greater detail. Should any questions arise concerning benefits, the SPD 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)

- Finally care services with an A or D recommendation by the Onlined States Freventive Services Task Folde (05-51

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 Membe

• 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 45 - 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 (50 to 80) who have a 20 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 iron deficiency, bacteriuria, hepatitis B virus, Rh factor incompatibility, gestational diabetes

Breastfeeding support/counseling & supplies, including lactation support services and counseling by a trained provider

and one 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 contraceptives and barrier methods, sterilization for women

Rx plan: Generic oral & injectable contraceptives, vaginal contraceptive, patch, prescription emergency contraception

Mon:

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 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 biese services or obschmittated in anouner way on the basis of race, color, national origin, age, disability or sex, you can file a grievance (Nondiscrimination Grievance). For heip with preparing and submitting your Nondiscrimination Grievance, contact a consumer advisor at the number on the back of your Memor ID card or call 1-800-665-9140 (TTY: 1-800-484-0298 or 711). There exercise the second the constraints for the time 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, tile a Nondiscrimination Grevance in person of by mail, fax or email. Address your Nondiscrimination Grevance to: Nondiscrimination Compliance Coordinator; clo Manager, Operations, Member Benefits Administration; 1 Cameron Hill Cricle, 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. https://ocrportal.lobby.jst.or by mail or phone at: U.S. Department of Health and Human Services, Department for Health and Furna Services, The Services, Services 200 Independence Avenue SW, Room 509F, HiHl Building, Washington, DC 20201, 1–800–388–1019, 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.

### 1 Cameron Hill Circle | Chattanooga, TN 37402 | bcbst.com

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

متحوظة. إذا كنت تحدث الذكر للقة. فإن خدمات المساعدة الفوية تتوافر لله بالمجان. التمل يرقم 1–9140-565-800 (رقم هالف التم وليكو: 1-800-848-2009).

#### 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 ban nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho ban. 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 ການບໍລິການຄ່ວຍເຫຼືອດ້ ານພາສາ, ໂດຍບໍ່ເສີຽຄຳ, ແມ່ນມີພ້ອມໃຫ້ທຳນ. ໂທຣ 1-800-565-9140 (TTY: 1-800-848-0298).

ማስታወዥ የሚናሉት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያንዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቀፕር ደደውሉ 1-800-565-9140 (መስማት ስተሳናቸው: 1-800-848-0298).

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

સુચના: જો તમે ગુજરાતી ઓવતા હો, તો નશ્વિક 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 दे∶ वदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलव्ध है। 1-800-565-9140 (TTY:1-800-848-0298) पर कॉल करे।

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

خرجه: اگر به زبان فارسی گفتگر می کنید، نسپینات زبانی بصور ت رابگان برای شما فراهم می بانند. با (1808-848-0298) 1100 (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 1-800-666-9140 (TTY: 1-800-848-0298).

Díí baa akó nínízin: Díí saad bee yáníttígo Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éi ná hóló, kojí' hódiilníh 1-800-665-9140 (TTY: 1-800-848-0298).