of Tennessee

Tusculum College

Benefit Summary

Effective Date: 4/1/2018
Network: S
Option/Quote: 3

Benefit Plan Features:	Your Cost In-Network	Your Cost Out-Of-Network [1]
Annual Deductible [19]		
Individual/Family	$6550/$13100	$13100/$26200
Annual Out-of-Pocket Maximum		
Individual/Family	$6550/$13100	$19650/$39300
4th Quarter Carry-over	Excluded	
Covered Services		
Preventive Care Services (see page 3 for a list)		
Well Child Care Services	Covered at 100%	20% after Deductible
Well Care Services	Covered at 100%	20% after Deductible
Annual Well Women Exam, Mammogram	Covered at 100%	20% after Deductible
Practitioner Office Services		
Primary Care Office Visits	0% after Deductible	20% after Deductible
Specialist Office Visits	0% after Deductible	20% after Deductible
Office Surgery [3, 4, 6]	0% after Deductible	20% after Deductible
Routine Diagnostic Lab, X-Ray & Injections	0% after Deductible	20% after Deductible
Advanced Radiological Imaging [2, 4, 7]	0% after Deductible	20% after Deductible
Provider-Administered Specialty Drugs [3]	0% after Deductible	20% after Deductible
Services Received at a Facility (includes professional and facility charges)		
Inpatient Services [2, 4]	0% after Deductible	20% after Deductible
Outpatient Surgery [3, 4, 6]	0% after Deductible	20% after Deductible
Routine Diagnostic Services - Outpatient	0% after Deductible	20% after Deductible
Advanced Radiological Imaging - Outpatient [2, 4, 7]	0% after Deductible	20% after Deductible
Other Outpatient Services [8]	0% after Deductible	20% after Deductible
Emergency Care Services [9, 10]	0% after Deductible	0% after Deductible
Emergency Care Advanced Radiological Imaging [7, 10]	0% after Deductible	0% after Deductible
Medical Equipment [3]		
Durable Medical Equipment	0% after Deductible	20% after Deductible
Prosthetics	0% after Deductible	20% after Deductible
Orthotic Appliances	0% after Deductible	20% after Deductible
Hearing Aids (under age 18)	0% after Deductible	20% after Deductible
Behavioral Health		
Inpatient: Unlimited days per annual benefit period [2, 4]	0% after Deductible	20% after Deductible
Outpatient: Unlimited visits per annual benefit period [5]	0% after Deductible	20% after Deductible
Therapy Services [11] (limits apply; see footnote)	0% after Deductible	20% after Deductible
Skilled Nursing Facility & Rehabilitation Facility Services [2, 4]		
Limited to 60 days combined per annual benefit period	0% after Deductible	20% after Deductible
Home Health Care Services [3, 4]		
Limited to 60 visits per annual benefit period	0% after Deductible	20% after Deductible

Benefit Plan Features:	Your Cost In-Network	Your Cost Out-Of-Network [1]
Hospice Services		
Inpatient [2]	0% after Deductible	20% after Deductible
Outpatient	0% after Deductible	20% after Deductible
Ambulance Service [3]	0% after Deductible	0% after Deductible
Prescription Drugs [3]		
Prescription Contraceptives [17]	Covered at 100%	20% after Deductible
Retail RX04 Network up to 30 day supply		
Generic [14]	0% after Deductible	20% after Deductible
Preferred [14, 16]	0% after Deductible	20% after Deductible
Non-Preferred [14, 16]	0% after Deductible	20% after Deductible
Plus90 or Home Delivery Network up to 90 day supply		
Generic [15]	0% after Deductible	20% after Deductible
Preferred [15, 16]	0% after Deductible	20% after Deductible
Non-Preferred [15, 16]	0% after Deductible	20% after Deductible
Preventive Drugs [18]		
Generic/Preferred/ Non-Preferred	$5/$25/$50	20% after Deductible
Self-Administered Specialty Drugs [3, 12, 13]		
Specialty Pharmacy Network - up to 30 day supply	0% after Deductible	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 charge.
2. Requires prior authorization.
3. Certain procedures, services, medication and equipment may require prior authorization.
4. If prior authorization is required, when using network providers outside Tennessee for physician and outpatient services and all services from out-of-network providers, benefits will be reduced by 10% based on out-of-network coinsurance if prior authorization is not obtained and services are medically necessary. 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., non-screening colonoscopy, sigmoidoscopy and endoscopy).
7. 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. Refer to the *Services Received at a Facility* section for applicable benefits related to the non-emergency use of emergency care services.
11. Physical, speech, spinal manipulative and occupational therapies are limited to 60 visits per therapy type per annual benefit period. Cardiac and pulmonary rehabilitative therapies are limited to 60 visits per therapy type per annual benefit period.
12. Visit www.bcbst.com 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 for a list of providers in the Specialty Pharmacy Network. Specialty drugs are limited to a 30-day supply.
14. Copay per prescription, up to 30 day supply (when copays apply).
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 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. This plan covers the following at 100%, in accordance with the Women's Preventive Services provision of the Affordable Care Act: generic contraceptives, vaginal ring, hormonal patch and emergency contraception available with a prescription. Visit www.bcbst.com for the Preferred Formulary which includes prescription contraceptives.
18. This plan provides copays for preventive care medications instead of having to meet your plan's deductible for certain prescription drugs. This list contains some of the most commonly prescribed preventive care drugs and is not all-inclusive. Visit www.bcbst.com for the Preventive Drug List.
19. Family plans have a per member deductible amount equal to the individual tier with a combined family limit. Members who satisfy the per member amount may access post-deductible benefits while other family members satisfy the family amount.

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

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

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

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

The following preventive care services are covered (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

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.

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, ໂດຍບໍ່ເສັ ຽຄ່າ, ແມ່ນມີ ພ້ ອມໃຫ້ ທ່ ານ. ໂທຣ 1-800-565-9140 (TTY: 1-800-848-0298).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ 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).

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