of Tennessee

Rhodes College

Effective Date: Jul 1, 2024

Network: S

Benefit Summary

Option/Quote: 12

Benefit Plan Features:	Your Cost In-Network	Your Cost Out-of-Network [1]
Annual Deductible		
Individual/Family	$500 / $1,500	$600/ $1,800
Annual Out-of-Pocket Maximum (includes copay, coinsurance and deductibles)		
Individual/Family	$3,000 (per person)	Unlimited
4th Quarter Carry-over	Excluded	
Covered Services		
Preventive Care Services (see page 3 for a list)	Covered at 100%	50% after deductible
Practitioner Office Services		
Primary Care Office Visits	20% after deductible	50% after deductible
Specialist Office Visits	20% after deductible	50% after deductible
Office Surgery [3, 4, 6]	20% after deductible	50% after deductible
Routine Diagnostic Lab, X-Ray & Injections	20% after deductible	50% after deductible
Advanced Radiological Imaging [2, 4, 7]	20% after deductible	50% after deductible
Teladoc™ Health Virtual Care [17]	$10 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	20% after deductible	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]	20% after deductible	20% after deductible
Emergency Care Advanced Radiological Imaging [7]	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 visits per annual benefit period [5]	20% after deductible	50% after deductible
Therapeutic Services [10] (limits apply; see footnote)	20% after deductible	50% after deductible
Skilled Nursing & Rehabilitation Facility Services [2, 4]		
Limited to 100 days combined per annual benefit period	20% after deductible	50% after deductible
Home Health Care Services [3, 4, 10]	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 [16]	Covered at 100%	50% after deductible
Retail RX04 Network up to 30 day supply [13]		
Preferred Generic	$10 copay	50% after deductible
Non-Preferred Generic	$10 copay	50% after deductible
Preferred Brand [15]	$30 copay	50% after deductible
Non-Preferred Brand [15]	$50 copay	50% after deductible
Plus90 or Home Delivery Network up to 90 day supply [14]		
Preferred Generic	$20 copay	50% after deductible
Non-Preferred Generic	$20 copay	50% after deductible
Preferred Brand [15]	$60 copay	50% after deductible
Non-Preferred Brand [15]	$100 copay	50% after deductible

Self-Administered Specialty Drugs [3, 11, 12]		
Preferred Specialty Drugs	$75 copay	Not Covered
Non-Preferred Specialty Drugs	$75 copay	Not Covered
Provider-Administered Specialty Drugs [3, 21]	20% after deductible	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.
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 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.
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. Physical, speech, acupuncture, spinal manipulative and occupational therapies are limited to 30 visits per therapy type per annual benefit period. Cardiac and pulmonary rehabilitative therapies are limited to 36 visits per therapy type per annual benefit period.
11. Visit 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 Evidence of Coverage (EOC) 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 Health'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/teladoc or call 1-800-TELADOC (1-800-835-2362) to register.
21. To receive benefits for provider-administered specialty drugs as identified on the provider-administered specialty drug list, you must use a Specialty 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.

Limitations and Exclusions. These pages summarize your health care plan benefits. Your Evidence of Coverage (EOC) defines the full terms and conditions, limitations, and exclusions 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 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 as deemed clinically appropriate by USPSTF and HRSA guidelines

• 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 as deemed clinically appropriate by USPSTF and HRSA guidelines

• 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

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.
Si usted es miembro, llame al número de Servicio de atención a miembros que figura al reverso de su tarjeta de identificación de Miembro o al 1-800-565-9140 (TTY: 1-800-848-0298).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان.
إذا كنت عضوًا، فاتصل برقم خدمة الأعضاء الموجود على ظهر بطاقة هوية العضو أو بالرقم 1-800-565-9140 (الهاتف النصي: 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。
若您是會員，請撥打會員 ID 卡背面的會員服務部號碼或 1-800-565-9140（聽障專線 (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.
Nếu quý vị là hội viên, hãy gọi đến số Dịch vụ Hội viên ở mặt sau thẻ ID Hội viên của quý vị hoặc 1-800-565-9140 (TTY: 1-800-848-0298).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
가입자의 경우, 가입자 ID 카드 뒷면의 가입자 서비스 전화번호 또는 1-800-565-9140(TTY: 1-800-848-0298)
번으로 전화하시기 바랍니다.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.
Si vous êtes adhérent, appelez le numéro du Service adhérents indiqué au dos de votre carte d'assuré adhérent ou appelez le 1-800-565-9140 (TTY/ATS : 1-800-848-0298).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ,ການບໍລິການຊ່ວຍເຫຼືອ ດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີໃຫ້ແກ່ທ່ານ.
ຖ້າທ່ານເປັນສະມາຊິກ, ໃຫ້ໂທຫາເຈົ້າໜ້າທີ່ບໍລິການລູກຄ້າທີ່ເບີໂທຢູ່ດ້ານຫຼັງບັດ ID ສະມາຊິກຂອງທ່ານ ຫຼື 1-800-565-9140
(TTY: 1-800-848-0298).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድጋፍ ለእርስዎት በነጻ ሊያገኙት ተዘጋጅተዋል።
አባል ከሆኑ በአባልነት መታወቂያዎ ጀርባ ላይ በሚገኘው የአባላት አገልግሎት ቁጥር ወይም በ 1-800-565-9140 (መስማት ለተሳናቸው፡
TTY: 1-800-848-0298) ይደውሉ።

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Falls Sie ein Mitglied sind, rufen Sie die Nummer des Mitgliederdienstes auf der Rückseite Ihrer Mitglieds-ID-Karte oder 1-800-565-9140 (TTY: 1-800-848-0298) an.

ધ્યાનમાં રાખો: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓનું તમારા માટે ઉપલબ્ધ છે.
જો તમે સભ્ય છો, તો તમારા સભ્ય આઈડી કાર્ડની પાછળના સભ્ય સર્વિસ નંબર ઉપર બોલાવો 1-800-565-9140 (TTY: 1-800-848-0298) પર કૉલ કરો.

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。
会員のお客様は、会員IDカードの裏面に記載の会員サービス番号あるいは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.
Kung ikaw ay isang miyembro, tawagan ang numero ng Serbisyo sa Miyembro na nasa likod ng iyong Kard ng ID ng Miyembro o 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।
अगर आप सदस्य हैं तो अपने सदस्य आईडी कार्ड के पीछे दिए गए नंबर या 1-800-565-9140 (TTY: 1-800-848-0298)
पर सदस्य सेवा नंबर पर कॉल करें।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
Если Вы являетесь участником, позвоните в отдел обслуживания участников по номеру, указанному на обратной стороне Вашей идентификационной карты участника, или по номеру 1-800-565-9140
(TTY: 1-800-848-0298).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
درصورتیکه عضو هستید، با شماره خدمات اعضا در پشت کارت شناسایی عضو خود یا 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.
Si ou se yon manm, rele nimewo Sèvis Manm ki sou do kat ID Manm ou an oswa 1-800-565-9140
(TTY: 1-800-848-0298).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej.
Członkowie mogą dzwonić pod numer działu Member Service podany na odwrocie karty identyfikacyjnej członka lub numer 1-800-565-9140 (TTY: 1-800-848-0298).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis.
Caso seja membro, ligue para o telefone do serviço de Atendimento ao Membro informado no verso de seu cartão de identificação de membro ou 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.
Se è un membro, chiami il numero del Servizio per i membri riportato sul retro della Sua scheda identificativa del membro oppure 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.
Naaltsoos bee nę́ ha'dit'éego, Naaltsoos Bá Hada'dit'éhígíí nínaaltsoos nitł'izí bee nééhozinígíí bine'dęę' Naaltsoos Bá Hada'dit'éhígíí Bee Aka'anída'awo'í bibéésh bee hane'í bíká'ígíí bee hodílnih doodago 1-800 -565-9140 (Doo Adinits'agóógo g TTY: 1-800-848-0298) bee hodílnih.