



Network: S

Option/Quote: CDHP

Benefit Plan Features:	Benefit Summary Your Cost In-Network	Your Cost Out-of-Network ¹
Annual Deductible ¹⁹ Individual/Family	\$1,700 / \$3,400	\$3,000 / \$6,000
Annual Out-of-Pocket Maximum (includes copay, coinsurance and deductibles) Individual/Family	\$3,000 / \$6,000	\$6,000 / \$12,000
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	10% after deductible	Not Covered
Specialist Office Visits	10% after deductible	Not Covered
Office Surgery ^{3, 4, 6}	10% after deductible	Not Covered
Routine Diagnostic Lab, X-Ray & Injections	10% after deductible	Not Covered
Advanced Radiological Imaging ^{2, 4, 7}	10% after deductible	Not Covered
Provider-Administered Specialty Drugs ^{3, 4}	10% after deductible	Not Covered
Services Received at a Facility (includes professional and facility charges)		
Inpatient Services ^{2, 4}	10% after deductible	Not Covered
Outpatient Surgery ^{3, 4, 6}	10% after deductible	Not Covered
Routine Diagnostic Services - Outpatient	10% after deductible	Not Covered
Advanced Radiological Imaging - Outpatient ^{2, 4, 7}	10% after deductible	Not Covered
Other Outpatient Services ⁸	10% after deductible	Not Covered
Urgent Care Center Services	10% after deductible	Not Covered
Emergency Care Services ⁹	10% after deductible	10% after deductible
Emergency Care Advanced Radiological Imaging ⁷	10% after deductible	10% after deductible
Medical Equipment Services ^{3, 4}		
Durable Medical Equipment	10% after deductible	Not Covered
Prosthetic or Orthotics	10% after deductible	Not Covered
Hearing Aids (under age 18)	Not Covered	Not Covered
Behavioral Health Services		
Inpatient: Unlimited days per annual benefit period ^{2, 4}	10% after deductible	Not Covered
Outpatient: Unlimited visits per annual benefit period ⁵	10% after deductible	Not Covered
Therapeutic Services ¹⁰ (limits apply; see footnote)		
Skilled Nursing & Rehabilitation Facility Services ^{2, 4}		
Limited to 60 days combined per annual benefit period	10% after deductible	Not Covered
Home Health Care Services ^{3, 4, 10}		
Hospice Services		
Inpatient ^{2, 4}	10% after deductible	Not Covered
Outpatient	10% after deductible	Not Covered
Ambulance Services ^{3, 4}		
	10% after deductible	10% after deductible

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, 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 -- 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, and occupational therapies are unlimited visits per therapy type per annual benefit period. Spinal manipulative therapy are limited to 20 visits per annual benefit period. Cardiac and pulmonary rehabilitative therapies are limited to 36 visits per therapy type per annual benefit period.
19. If more than one person is covered under the group health plan, the full family deductible must be satisfied before benefits will be paid for the employee or any covered family members.

[Limitations and Exclusions](#). These pages summarize your health care plan. Your Evidence of Coverage (EOC) define 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 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

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

