EHB Medical Prospect Benefit Summary

Effective Sep 1, 2023

Group: BenefitHelp Inc.

Group ID: 170127 - 1

Plan Information: Gold 112S ($3500/$6000/80%)

Effective Date: 09/01/2023

Network: Blue Network S

Benefit Plan Features	Cost In-Network	Cost Out-of-Network
Annual Deductible		
Individual/Family	$3,500 / $7,000	$7,000 / $14,000
Annual Out-of-Pocket Maximum (includes copays, coinsurance and deductibles)		
Individual/Family	$6,000 / $12,000	$18,000 / $36,000
Covered Services		
Preventive Care Services [13] (see Page 3 for a list)	Covered at 100%	50% after Deductible
Practitioner Office Services		
Primary Care Office Visits	$25 Copay	50% after Deductible
Specialist Office Visits	$50 Copay	50% after Deductible
Office Surgery [4,5,6]	20% after Deductible	50% after Deductible
Routine Diagnostic Lab, X-Ray & Injections	$25 Copay	50% after Deductible
Advanced Radiological Imaging [3, 5, 7]	20% after Deductible	50% after Deductible
Teladoc Health Virtual Care	Covered at 100%	Not Covered
Services Received at a Facility (includes professional and facility charges)		
Inpatient Services [3, 5]	20% after Deductible	50% after Deductible
Outpatient Surgery [4, 5, 6]	20% after Deductible	50% after Deductible
Routine Diagnostic Services – Outpatient	$25 Copay	50% after Deductible
Advanced Radiological Imaging - Outpatient [3, 5, 7]	20% after Deductible	50% after Deductible
Other Outpatient Services [8]	20% after Deductible	50% after Deductible
Urgent Care Center Services	$50 Copay	50% after Deductible
Emergency Care Services [10]	$750 + Ded/Coin	$750 + Ded/Coin
Emergency Care Advanced Radiological Imaging [7]	20% after Deductible	20% after Deductible
Skilled Nursing & Rehabilitation Facility Services [3, 5]		
Limited to 60 days combined per annual benefit period	20% after Deductible	50% after Deductible
Medical Equipment [4, 5]		
Durable Medical Equipment	20% after Deductible	50% after Deductible
Prosthetics or Orthotics	20% after Deductible	50% after Deductible
Hearing Aids [22]	20% after Deductible	50% after Deductible
Behavioral Health Services		
Inpatient: Unlimited days per annual benefit period [3, 5]	20% after Deductible	50% after Deductible
Outpatient: Unlimited days per annual benefit period [14,18]	$25 Copay	50% after Deductible

Therapy Services		
Rehabilitative [4, 5, 9] & Habilitative [4, 5, 21] Limits apply; See footnotes	20% after Deductible	50% after Deductible
Home Health Care Services [4, 5, 9, 21]	20% after Deductible	50% after Deductible
Hospice Services [5, 23]	Covered at 100%	50% after Deductible
Ambulance Services [4]	20% after Deductible	20% after Deductible

Prescription Drugs [4, 11, 12, 16, 20]

Prescription Contraceptives [16]	Covered at 100%	50% after Deductible
Retail Network, Plus90 or Home Delivery Network [15]		
Generic	$10 Copay	50% after Deductible
Preferred	$35 Copay	50% after Deductible
Non-Preferred	$50 Copay	50% after Deductible
Self-administered Specialty Drugs [17, 24]		
Preferred Specialty Pharmacy Network	Covered at 50%	Not Covered
Provider-administered Specialty Drugs [4, 17]		
Preferred Specialty Pharmacy Network	Covered at 50%	Not Covered

Notes

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. The lower copay applies to Family Medicine, General Practice, General Internal Medicine, OB/GYN, Pediatrics, and Behavioral Health services. The copay for Physician Assistants or Nurse Practitioners may be based on the provider type of the billing provider.
3. Prior authorization is required.
4. Certain procedures, services, medication and equipment may require prior authorization.
5. 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, benefits will be reduced to Covered at 50%. If services are not medically necessary, no benefits will be provided.
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. Physical, speech, acupuncture, spinal manipulation and occupational therapies are limited to 20 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.
10. Copay, if applicable, waived if admitted to hospital.
11. Visit www.bcbst.com/rx for the Essential Formulary which includes specialty drugs.
12. Copay, if applicable, applied per prescription, up to a 30 day supply.
13. Services include annual physical, childhood immunizations, recommended adult immunizations and vision and hearing screenings performed by the physician during the preventive health exam.
14. 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.
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 continue to refill a Prescription that a Practitioner will prescribe in a ninety (90) day supply at a non-Plus90 Retail Network Pharmacy after the third fill, Your claim will be denied. Visit www.bcbst.com/rx to find a list of pharmacies in the Plus90 Network.
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 on the drug formulary with an "ACA" indicator. Visit www.bcbst.com/rx for the Essential Plus Formulary.
17. You have a distinct network for self-administered specialty drugs and provider-administered specialty drugs. To receive benefits, you must use a Preferred Specialty Pharmacy Network provider. Visit www.bcbst.com/rx for a list of providers in the Preferred Specialty Pharmacy Network. Self-administered specialty drugs are limited to a 30 day supply.
18. If applicable, the office visit copay limit applies to office visits for medical and behavioral health conditions combined.
19. If applicable, 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/rx for the Essential Formulary.
20. 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.
21. Therapy Services - Habilitative: Physical, speech and occupational therapies are limited to 20 visits per therapy type per annual benefit period.
22. Limited to 1 per ear every 3 years.
23. Inpatient Hospice requires prior authorization.
24. If you receive Copay Assistance that discounts the cost of certain Specialty Drugs, the Plan may reduce the benefits it provides in proportion to the amount of the Copay Assistance. Additionally, the Plan may exclude from accumulation toward any Deductible or Out-of-Pocket Maximum the value of any Copay Assistance applied to any Copayment, Deductible and/or Coinsurance that the Plan would require you to pay if you did not receive the Copay Assistance.

Limitations and Exclusions: These pages summarize the benefits of your health care plan. Your Evidence of Coverage (EOC) defines 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 Care Services Covered at 100%

Effective Sep 1, 2023

Group: BenefitHelp Inc. **Group ID:** 170127 - 1

Plan Information: Gold 112S ($3500/$6000/80%)

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 (age 45 and older for women; age 35 and older for men), high blood pressure, obesity, diabetes and depression (age 12 and older)
- Screening for lung cancer for adults (age 50 - 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 primary care setting for alcohol misuse and tobacco use; alcohol misuse and tobacco cessation counseling limited to 8 visits per type per annual benefit period
- Dietary counseling for adults with hyperlipidemia, hypertension, type 2 diabetes, obesity, coronary artery disease and/or 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 and supplies, including lactation support services and counseling by a trained provider and one breast pump per pregnancy
- Counseling women at high risk of breast cancer for chemoprevention, including risks and benefits
- Mammography screening (age 40 and older) and genetic counseling and, if indicated after counseling, BRCA testing for BRCA breast cancer gene
- Osteoporosis screening (age 60 and 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

Men:

- Prostate cancer screening (age 50 and older)
- One-time abdominal aortic aneurysm screening (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

Pediatric Dental [2]

Benefit Plan Features	Your Cost In-Network	Your Cost Out-Of-Network [1]
Coverage A Diagnostic and Preventive Services Exams Cleanings X-rays	No Member Cost Share	No Member Cost Share
Coverage B Basic Restorative Services Basic Endodontics and Periodontics Oral Surgery	20%	20%
Coverage C Major Restorative and Prosthodontics Major Endodontics and Periodontics Implants	50%	50%
Coverage D (Requires Prior Authorization) Medically Necessary Orthodontia	20% after Deductible	50% after Deductible

Pediatric Vision [2]

Benefit Plan Features	Your Cost In-Network	Your Cost Out-Of-Network [1]
Exams [3] Comprehensive Eye Exam Contact Lens Fitting and Follow-up (Limited to two)	No Member Cost Share	40%
Frames [4] Designated available frame at provider location	No Member Cost Share	40%
Standard Lenses (Glass or Plastic) [3, 4] Single Bifocal Trifocal Lenticular Standard Progressive	No Member Cost Share	40%
Lens Options [3, 4] Standard Polycarbonate UV Treatment Tint Standard Plastic Scratch Coating Photochromic/Transitions Plastic	No Member Cost Share	40%
Contacts (includes materials only) [3, 4] Extended Wear/Extended Wear Disposables Daily Wear/Disposables	No Member Cost Share	40%

Notes

1. Out-of-network benefit payment based on maximum allowable charge. You are responsible for paying any amount exceeding the maximum allowable charge.
2. Coverage for members under age 19 only.
3. Vision Exams, eyeglass frames and lenses and contact lenses are covered once every annual benefit period. Prescription Sunglasses will be handled as any other lens.
4. Certain restrictions apply.

Limitations and Exclusions: These pages summarize the benefits of your health care plan. Your Evidence of Coverage (EOC) defines 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.

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 (for TTY help, call 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
(TTY:1-800-848-0298) 1-800-565-9140 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'dę́ę́', t'áá jiik'eh, éí ná hólǫ́, kojį' hódíílnih 1-800-565-9140 (TTY: 1-800-848-0298).