of Tennessee

City of Cleveland/Cleveland Utilities
Benefit Summary

Effective Date: 8/1/2017
Option 1: Network S
Option 2: Network P

Benefit Plan Features:	Your Cost In-Network	Your Cost Out-Of-Network [1]
Annual Deductible		
Individual/Family	$2500/$5000	$5000/$10000
Annual Out-of-Pocket Maximum		
Individual/Family	$3000/$6000	$9000/$18000
4th Quarter Carry-over	Excluded	
Covered Services		
Preventive Care Services [2] (see page 3 for a list)		
Well Child Care Services	Covered at 100%	40% after Deductible
Well Care Services [2]	Covered at 100%	40% after Deductible
Annual Well Women Exam, Mammogram	Covered at 100%	40% after Deductible
Practitioner Office Services		
Primary Care Office Visits	20% no Deductible	40% after Deductible
Specialist Office Visits	20% no Deductible	40% after Deductible
Office Surgery [4][5][6]	20% no Deductible	40% after Deductible
Routine Diagnostic Lab, X-Ray & Injections	20% no Deductible	40% after Deductible
Advanced Radiological Imaging [3][5][7]	20% after Deductible	40% after Deductible
Provider-Administered Specialty Drugs [11]	$140 Copay	40% after Deductible
Services Received at a Facility (includes professional and facility charges)		
Inpatient Services [3][5]	$150 copay then 20% after Deducible	40% after Deductible
Outpatient Surgery [4][5][6]	20% after Deductible	40% after Deductible
Routine Diagnostic Services - Outpatient	20% no Deductible	40% after Deductible
Advanced Radiological Imaging - Outpatient [3][5][7]	20% after Deductible	40% after Deductible
Other Outpatient Services [8]	20% after Deductible	40% after Deductible
Emergency Care Services[9]	$250 Copay	$250 Copay
Emergency Care Advanced Radiological Imaging [7]	20% after Deductible	20% after Deductible
Medical Equipment [4]		
Durable Medical Equipment	20% after Deductible	40% after Deductible
Prosthetics	20% after Deductible	40% after Deductible
Orthotic Appliances	20% after Deductible	40% after Deductible
Hearing Aids (under age 18)	20% after Deductible	40% after Deductible
Behavioral Health		
Inpatient: Unlimited days per annual benefit period [3][5]	$150 copay then 20% after Deducible	40% after Deductible
Outpatient: Unlimited visits per annual benefit period	20% no Deductible	40% after Deductible
Therapy Services[10] Limited to 30-36 visits per annual benefit period per therapy type	20% no Deductible	40% after Deductible
Skilled Nursing Facility & Rehabilitation Facility Services [3][5] Limited to 60 days combined	20% after Deductible	40% after Deductible
Home Health Care Services [3] Limited to 120 visits per annual benefit period	20% after Deductible	40% after Deductible

City of Cleveland

Cleveland, TN

Group Medical Renewal Options

August 1, 2017- July 31, 2018

	Option # 1	Option # 2
	Blue Cross	Blue Cross
Benefits	Blue Shield of TN	Blue Shield of TN
Network	Network S	Network P
Physician Office Visit		
MD Live Consultation	*NO COPAY*	
Primary Care	20% Coinsurance ONLY	
Specialist	20% Coinsurance ONLY	
Prescription Drug Card		
Generic	$10 Copay	$10 Copay
Brand Name	$35 Copay	$35 Copay
Non-Preferred Brand	$70 Copay	$70 Copay
Mail order	*3 x Copay*	*3 x Copay*
Outpatient Diagnostic		
Routine	20% Coinsurance ONLY	
Non-Routine Diagnostic	20% after Deductible	
Inpatient Hospital	$150 CP + Ded & Coins	$150 CP + Ded & Coins
Deductible	*Plan Year*	*Plan Year*
In-Network(Ind/Family)	**$2,500 / $5,000**	**$2,500 / $5,000**
Out-of-Network	2x	2x
Co-Insurance		
In-Network	80% / 20%	80% / 20%
Out-of-Network	60% / 40%	60% / 40%
Out-of-Pocket Maximum		
In-Network	**$3,000 / $6,000**	**$3,000 / $6,000**
Out-of-Network	3x	3x
Maternity	$150 CP + Ded & Coins	$150 CP + Ded & Coins
ER Visit	$250 Copay	$250 Copay
Outpatient Surgery	20% after Deductible	
Preventive Health	*Paid at 100%*	*Paid at 100%*
Rehabilitation Services	20% Coinsurance ONLY	
Mental Health	Parity Law Applies	
Ambulance Services	20% after Deductible	
Allergery Testing	20% Coinsurance ONLY	
Vision Benefit	No Routine Vision	
Lifetime Maximum Benefit	*Unlimited*	*Unlimited*
	Active/pre-65	Active/pre-65
Premium	**2017-2018 Employee Monthly Contribution**	
EE Only	$0.00	$5.70
Family	$370.34	$385.44

Questions:

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Secure Access to your Plan Information

WWW.BCBST.COM

Login to BlueAccess to signup for MD Live

Reimbursement Plan:

Inpatient Copay: City/CU will reimburse $100 of the $150 IP Copay (EOB required)

Deductible: City/CU will reimburse OOPM expenses between $2,501 - $3,000 (Limited to $500 value per EMPLOYEE- EOB Required)

Deductible + Coinsurance + Copays = Out-of-Pocket Maximums

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. Coverage of some services may depend on age and/or risk exposure.

All Members:

- One-a-year preventive health exams. 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, high blood pressure, obesity, diabetes, and depression
- 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; tobacco cessation counseling in the primary care setting will be limited to eight visits per year
- Dietary counseling for adults with hyperlipidemia, hypertension, Type 2 diabetes, obesity, coronary artery disease and congestive heart failure; limited to six visits per year

Women:

- Annual well-woman visit, including annual sexually transmitted infection (STI) counseling and annual domestic violence screening & counseling
- Cervical Cancer Screening
- Screening of pregnant women for anemia, iron deficiency, bacteriuria, hepatitis B virus, Rh factor incompatibility, gestational diabetes
- Breastfeeding support/counseling & supplies (one lactation consultant visit and manual breast pump in conjunction with each birth)
- Counseling women at high risk of breast cancer for chemoprevention, including risks and benefits
- Mammography screening at age 40 and over, and evaluation for genetic testing for BRCA breast cancer gene
- Osteoporosis screening (age 60 or older)
- HPV testing once every 3 years, beginning at age 30
- Annual HIV screening and counseling
- 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
- 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
- Screening for major depressive disorders

Benefit Plan Features:	Your Cost In-Network	Your Cost Out-Of-Network [1]
Hospice Services		
Inpatient [3]	Covered at 100%	40% after Deductible
Outpatient	Covered at 100%	40% after Deductible
Ambulance Service	20% after Deductible	20% after Deductible
Prescription Drugs [4]		
Prescription Contraceptives [16]	Covered at 100%	40% after Deductible
Retail RX04 Network - up to 30 day supply		
Generic [13] [15] [17]	$10.00	40% after Deductible
Preferred [13] [15] [17]	$35.00	40% after Deductible
Non-Preferred [13] [15] [17]	$70.00	40% after Deductible
Plus90 or Home Delivery Network - up to 90 day supply		
Generic [14] [15]	$30.00	40% after Deductible
Preferred [14] [15]	$105.00	40% after Deductible
Non-Preferred [14] [15]	$210.00	40% after Deductible
Self-Administered Specialty Drugs [11] [12] [15]		
Specialty Pharmacy Network - up to 30 day supply	$140.00	Not Covered

Notes:

1. Out-of-network benefit payment based on BlueCross BlueShield of Tennessee maximum allowable charge. You are responsible for paying any amount exceeding the maximum allowable charge.
2. Services include: annual physical, childhood immunizations, recommended adult immunizations, vision and hearing screenings performed by the physician during the preventive health exam.
3. Requires prior authorization.
4. Certain procedures, medication and equipment may require prior authorization.
5. 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 if prior authorization is not obtained and services are medically necessary. 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).
7. CT scans, PET scans, MRIs, nuclear medicine and other similar technologies.
8. Includes services such as chemotherapy, radiation therapy and renal dialysis.
9. Copay, if applicable, waived if admitted to hospital.
10. Physical, speech, 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 bcbst.com for the Specialty Drug List.
12. You have a distinct arrangement for Self-administered Specialty Drugs. To receive benefits, you must use a Specialty Pharmacy Network provider. Visit bcbst.com for a list of providers in the Specialty Pharmacy Network. Specialty drugs are limited to a 30-day supply.
13. Copay per prescription, up to 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 bcbst.com 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. 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, emergency contraception available with a prescription. Visit bcbst.com for a complete list of covered prescription contraceptive drugs.
17. Vaccines administered at the pharmacy are covered at 100%.

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.