of Tennessee

Ballad Health

Benefit Summary

Effective Date: 7/1/2023
Network: S
Option: Choice Plan

Benefit Plan Features:	Your Cost at Ballad Health and BHMA Providers Tier 1	Your Cost at Ballad Preferred Providers (ISHN) Tier 2	Your Cost In-Network PPO Network S Tier 3	Your Cost Out-Of-Network [1]
Non-Embedded Annual Deductible				
Individual/Family	$1,500/$3,000		$2,500/$5,000	$2,500/$5,000
Embedded Annual Out-of-Pocket Maximum Not to Exceed Affordable Care Act OOP (includes copays, coinsurance, and deductibles)				
Individual/Family	$3,500/$7,000		$6,000/$12,000	$20,000/$20,000
Individuals within a Family Plan shall not exceed an Annual Out of Pocket Maximum of *$7500* for In-Network Services.				
4th Quarter Carry-over	Excluded			

Covered Services	Your Cost In-Network			Your Cost Out-Of-Network [1]
Preventive Care Services (see page 3 for a list)				
Well Child Care Services	Covered at 100%			Not Covered
Well Care Services	Covered at 100%			Not Covered
Annual Well Woman Exam, Mammogram	Covered at 100%			Not Covered
Practitioner Office Services				
Primary Care Office Visits	10% after deductible	10% after deductible	30% after deductible	50% after deductible
Specialist Office Visits	10% after deductible	10% after deductible	30% after deductible	50% after deductible
Office Surgery [3, 4, 6]	10% after deductible	10% after deductible	30% after deductible	50% after deductible
Routine Diagnostic Lab, X-Ray & Injections	10% after deductible	10% after deductible	30% after deductible	50% after deductible
Lab Work	0% after deductible	20% after deductible	30% after deductible	50% after deductible
Advanced Radiological Imaging [2, 4, 7]	0% after deductible	20% after deductible	30% after deductible	50% after deductible
Provider-Administered Specialty Drugs [3]	10% after deductible	10% after deductible	30% after deductible	50% after deductible

Covered Services	Your Cost at Ballad Health and BHMA Providers Tier 1	Your Cost at Ballad Preferred Providers (ISHN) Tier 2	Your Cost In-Network PPO Network S Tier 3	Your Cost Out-Of-Network [1]
Services Received at a Facility (includes professional and facility charges)				
Inpatient Services [2, 4]	10% after deductible	10% after deductible	30% after deductible	50% after deductible
Outpatient Surgery [3, 4, 6]	10% after deductible	10% after deductible	30% after deductible	50% after deductible
Routine Diagnostic Services - Outpatient	10% after deductible	10% after deductible	30% after deductible	50% after deductible
Advanced Radiological Imaging - Outpatient [2, 4, 7]	0% after deductible	20% after deductible	30% after deductible	50% after deductible
Other Outpatient Services [8]	10% after deductible	10% after deductible	30% after deductible	50% after deductible
Urgent Care Center Services	10% after deductible	10% after deductible	30% after deductible	50% after deductible
Emergency Care Services [9,10]	10% after deductible	10% after deductible	10% after deductible	10% after deductible
Emergency Care Advanced Radiological Imaging [7,10]	10% after deductible	10% after deductible	10% after deductible	10% after deductible
Inpatient [2, 4] or Outpatient: Physician Charges	10% after deductible	10% after deductible	30% after deductible	50% after deductible
Medical Equipment Services [3]				
Durable Medical Equipment	10% after deductible	10% after deductible	30% after deductible	50% after deductible
Prosthetics or Orthotics	10% after deductible	10% after deductible	30% after deductible	50% after deductible
Behavioral Health Services				
Inpatient: Unlimited days per annual benefit period [2, 4]	10% after deductible	10% after deductible	30% after deductible	50% after deductible
Outpatient: Unlimited visits per annual benefit period [5]	10% after deductible	10% after deductible	30% after deductible	50% after deductible
Therapeutic Services [11] (limits apply; see footnote)				
	0% after deductible	20% after deductible	30% after deductible	50% after deductible

Skilled Nursing Facility & Rehabilitation Facility Services [2, 4]				
Limited to 100 days combined per annual benefit period	10% after deductible	10% after deductible	30% after deductible	50% after deductible
Physician Charges	10% after deductible	10% after deductible	30% after deductible	50% after deductible
Home Health Care Services [3, 4]				
Unlimited visits per annual benefit period	10% after deductible	10% after deductible	30% after deductible	50% after deductible
Hospice Services				
Inpatient [2]	10% after deductible	10% after deductible	30% after deductible	50% after deductible
Outpatient	10% after deductible	10% after deductible	30% after deductible	50% after deductible
Ambulance Services [3]	10% after deductible	10% after deductible	30% after deductible	30% after deductible

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.
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 50% based on out-of-network coinsurace. 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. In true emergency situations, out-of-network emergency services apply to the in-network deductible and/or out of pocket maximum.
11. Physical, speech, spinal manipulative and occupational therapies are limited to **60** visits combined per annual benefit period.
    Spinal manipulative therapy has a limit of **6** visits per benefit period.
    Cardiac and pulmonary rehabilitative therapies are limited to **36** visits per therapy type with a cap of **72** visits per annual benefit period.

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 Care Services
Covered at 100% In-Network

In-network preventive 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 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 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 breast pump per pregnancy
- Counseling 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.

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: ຖ້າ ວ່າ ທ່ານ ເວົ້າ ພາສາ ລາວ, ການ ບໍ ລິ ການ ຊ່ວຍ ເຫລືອ ດ້ານ ພາສາ, ໂດຍ ບໍ ເສັ ຽ ຄ່າ ໃ, ດ ກໍ ພ້ ອມ ໃຫ້ ທ່ ານ. ໂທຣ 1-800-565-9140 (TTY: 1-800-848-0298).

ማስታወሻ: የሚናገሩት ቋንቋ ኦሮሚኛ 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).

સૂચના: 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 है तो आपके लिए मुफ्त मे भाषा सहायता सेवाएं उपलब्ध है। 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).

خوجه: 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'dęę́', t'áá jiik'eh, éí ná hóló, koji' hódíílnih 1-800-565-9140 (TTY: 1-800-848-0298).