5. Additional Quote Requirements for TPA/ASO & Associated Vendors

Please attach this form to the front of your proposal

ATTACHMENT TO RFP: ADMINISTRATIVE SERVICES

Third Party Administrator or ASO Provider: BlueCross BlueShield of Tennessee

Contact Information: Wayne Webb, (865) 588-4634

This form must be completed according to how administrative fees are applicable to your organization.

- *All rates should be provided as a PEPM (per emolovee per month) charge unless otherwise indicated.*

Quote based on requested benefits in RFP with Transparent Pharmacy Pricing

Base Administration	$33.39 PEPM
Rx Admin Fee: Transparent Pricing (RX03)	$4.00 PEPM
COBRA Administration	$1.00 PEPM
Utilization Review/Medical Management	Included at no additional charge
Name of UR/Case Management Organization	BlueCross BlueShield of Tennessee
Disease Management/Wellness Program Fee	$2.42 PEPM (Chronic Care Management)
PPO Administration/Coordination Fee	Included at no additional charge
PPO Access Fee	See BlueCard® PPO fees below*
Rx Administration/Coordination Fee	Included at no additional charge
Medicare Part D Notices & Testing	Not applicable
HRA Administration	$4.00 PEPM
Other Fee- - - - -	See optional services below**
TOTAL MONTHLY FEES	Based on services selected
Other Annual Fees (if applicable)	If stop loss is carved out there is an interface fee of $1.40 PEPM. If prescription drug coverage is carved out, there is an interface fee of $1.43 PEPM.
Setup (One-time fee)	None
Are on-line administrative services available?	Yes
Is a copy of your EOB included?	Yes; included as **Attachment #9**
Rate guarantees (please specify)	07/01/19 – 06/30/20

***BlueCard Fees**
The above fee includes network fees in the state of Tennessee and its contiguous counties.
For services obtained outside of the state of Tennessee and contiguous counties, all BlueCard PPO claims are subject to the following fees:

- Administration Fee of $5 per professional claim and $11 per institutional claim
- Access Fee of 4.14% of the provider savings, not to exceed $2,000 per claim.

****Optional Services**

Healthy Maternity℠	$0.46 PEPM
PhysicianNow℠ telehealth (medical only)	$0.63 PEPM
Advanced Radiological Imaging (formerly High Tech Imaging)	$1.04 PEPM
Musculoskeletal Prior Authorization	$0.85 PEPM
Genetic Testing Prior Authorization	$0.27 PEPM
Lifestyle Health Coaching	$2.88 PEPM
BlueHealth Rewards (Activate)	$1.52 PEPM
FSA Administration	$5.00 PAPM; plan set up fee and maintenance fees will apply and vary based on the number of accounts enrolled. + Accounts 1-499: $250 plan set up and $250 annual plan maintenance fee. + Accounts 500-999: $500 plan set up and $500 annual plan maintenance fee.
Self-Funded Dental Administration	$3.50 PEPM; if The County selects BlueCross for both Medical and Vision the Dental Administration fee will be reduced to $3.25 PEPM (guaranteed for three years).

Conditions
BlueCross retains the right to adjust the administrative services fee to cover reasonably anticipated cost variations resulting from:

- Changes in the Plan, Legislation or Regulation
- Termination or addition of a subsidiary, operation or class of employee
- Fluctuation of the actual number of covered employees by +/- 10% by location, state and/or in aggregate from the 328 contracts the quote was based on.

of Tennessee

Anderson County Government
Benefit Summary

Effective Date: 7/1/2019
Network: P
Option: 1 Quote: 112

Benefit Plan Features:	Your Cost In-Network	Your Cost Out-Of-Network [1]
Annual Deductible		
Individual/Family	$1000/$2000	$2000/$4000
Annual Out-of-Pocket Maximum (includes copays, coinsurance and deductibles)		
Individual/Family	$4000/$8000	$12000/$36000
4th Quarter Carry-over	Included	
Covered Services		
Preventive Care Services (see page 3 for a list)	Covered at 100%	50% after Deductible
Practitioner Office Services		
Primary Care Office Visits [2]	$35 Copay	50% after Deductible
Specialist Office Visits	$50 Copay	50% after Deductible
Office Surgery [2, 4, 5, 7]	20% after Deductible	50% after Deductible
Routine Diagnostic Lab, X-Ray & Injections	No Additional Copay	50% after Deductible
Advanced Radiological Imaging [3, 5, 8]	20% after Deductible	50% after Deductible
Provider-Administered Specialty Drugs [4]	No Additional Copay	50% after Deductible
Services Received at a Facility (includes professional and facility charges)		
Inpatient Services [3, 5]	20% after Deductible	50% after Deductible
Outpatient Surgery [4, 5, 7]	20% after Deductible	50% after Deductible
Routine Diagnostic Services - Outpatient	100% (no Deductible)	50% after Deductible
Advanced Radiological Imaging - Outpatient [3, 5, 8]	20% after Deductible	50% after Deductible
Other Outpatient Services [9]	20% after Deductible	50% after Deductible
Urgent Care Center Services	$50 Copay	50% after Deductible
Emergency Care Services [10, 11]	$500 Copay then 20% Coinsurance	$500 Copay then 20% Coinsurance
Emergency Care Advanced Radiological Imaging [8, 11]	20% after Deductible	20% after Deductible
Medical Equipment Services [4, 5]		
Durable Medical Equipment	20% after Deductible	50% after Deductible
Prosthetics 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 [3, 5]	20% after Deductible	50% after Deductible
Outpatient: Unlimited visits per annual benefit period [6]	$35 Copay	50% after Deductible
Therapeutic Services [12] (limits apply; see footnote)		
Chiropractic exam $50 Copay then 100%.	20% after Deductible	50% after Deductible
Skilled Nursing & Rehabilitation Facility Services [3, 5]		
Limited to 60 days combined per annual benefit period	20% after Deductible	50% after Deductible
Home Health Care Services [4, 5]		
Unlimited visits	20% after Deductible	50% after Deductible

Benefit Plan Features:	Your Cost In-Network	Your Cost Out-Of-Network [1]
Hospice Services		
Inpatient [3]	20% after Deductible	50% after Deductible
Outpatient	20% after Deductible	50% after Deductible
Ambulance Services [4, 5]	20% after Deductible	20% after Deductible
Prescription Drugs [4]		
Prescription Drug Out of Pocket Maximum Separate from Medical Out of Pocket Maximum	$2000 Individual $4000 Family	**Prescription Drug Out-of-Network Out of Pocket Maximum applies to Medical Out of Pocket Maximum**
Prescription Contraceptives [18]	Covered at 100%	50% after Deductible
Retail RX03 Network up to 30 day supply		
Generic [15]	$10 Copay	50% after Deductible
Preferred [15, 17]	30% with a Maximum of $125	50% after Deductible
Non-Preferred [15, 17]	30% with a Minimum of $30 and Maximum of $175	50% after Deductible
Plus90 or Home Delivery Network up to 90 day supply		
Generic [16]	$20 Copay	50% after Deductible
Preferred [16, 17]	$60 Copay	50% after Deductible
Non-Preferred [16, 17]	$80 Copay	50% after Deductible
Retail RX03 Network BCBST Preventive Drug List up to 30 day supply		
Generic [16]	$10 Copay	50% after Deductible
Preferred [16, 17]	$30 Copay	50% after Deductible
Non-Preferred [16, 17]	$40 Copay	50% after Deductible
Plus90 or Home Delivery Network BCBST Preventive Drug List up to 90 day supply		
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Preferred [16, 17]	$60 Copay	50% after Deductible
Non-Preferred [16, 17]	$80 Copay	50% after Deductible
Self-Administered Specialty Drugs [4, 13, 14]		
Specialty Pharmacy Network - up to 30 day supply	30% with a Minimum of $30 and Maximum of $175	Not Covered

Notes:

1. Out-of-network benefit payment based on BlueCross BlueShield of Tennessee maximum allowable charge. You are responsible for any unpaid billed charges.
2. The lower copay applies to Family Practice, General Practice, Internal Medicine, OB/GYN, Pediatrics, Behavioral Health and Health Department 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.
   Specialty drugs are limited to a 30-day supply, and only covered at 100% when administered in an office visit.
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, your liability will be increased to 50% based on out-of-network coinsurance. If services are not medically necessary, no benefits will be provided.
6. 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.
7. 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).
8. Includes CT scans, PET scans, MRIs, nuclear medicine and other similar technologies.
9. Includes services such as chemotherapy, infusions, injections, radiation therapy and renal dialysis.
10. Copay, if applicable, waived if admitted to hospital.
11. In true emergency situations, out-of-network emergency services apply to the in-network deductible and/or out-of-pocket maximum.
12. Physical, speech, spinal manipulative and occupational therapies are limited to 25 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.
13. Visit www.bcbst.com for the Preferred Formulary which includes specialty drugs and preventive drug list.
14. You have a distinct arrangement for self-administered specialty drugs. To receive benefits, you must use a Specialty Pharmacy Network provider. Visit www.bcbst.com for a list of providers in the Specialty Pharmacy Network.
    Specialty drugs are limited to a 30-day supply.
15. Copay, if applicable, applied per prescription, up to a 30 day supply.
16. 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 to find a list of pharmacies in the Plus90 Network.
17. 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.
18. 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 for the Preferred Formulary.

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 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 50 – 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 (55 to 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 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

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 manual 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 hormonal contraceptives and barrier methods, sterilization for women

  Rx plan: Generic oral & injectable contraceptives, vaginal contraceptive, patch, prescription emergency contraception

- 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 لذكر 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 ວ່າ ການ ຊ່ວຍ ເຫລືອ ດ້ານ ພາສາ, ໂດຍ ບໍ ເສັ ຽ ຄ່າ ໃ, ແມ ນ ພ ອມ ທີ ທ່ ານ. ໂທ 1-800-565-9140 (TTY: 1-800-848-0298).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ 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 નિઃશુલ્ક 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 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).

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

of Tennessee

Anderson County Government
Benefit Summary

Effective Date: 7/1/2019
Network: P
Option: 2 Quote: 113

Benefit Plan Features:	Your Cost In-Network	Your Cost Out-Of-Network [1]
Annual Deductible		
Individual/Family	$1500/$3000	$3000/$6000
Annual Out-of-Pocket Maximum (includes copays, coinsurance and deductibles)		
Individual/Family	$4000/$8000	$12000/$36000
4th Quarter Carry-over	Included	
Covered Services		
Preventive Care Services (see page 3 for a list)	Covered at 100%	50% after Deductible
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Benefit Plan Features:	Your Cost In-Network	Your Cost Out-Of-Network [1]
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Non-Preferred [15, 17]	30% with a Minimum of $30 and Maximum of $175	50% after Deductible
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Notes:

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3. Prior authorization is required.
4. Certain procedures, services, medication and equipment may require prior authorization.
   Specialty drugs are limited to a 30-day supply, and only covered at 100% when administered in an office visit.
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6. 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.
7. 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).
8. Includes CT scans, PET scans, MRIs, nuclear medicine and other similar technologies.
9. Includes services such as chemotherapy, infusions, injections, radiation therapy and renal dialysis.
10. Copay, if applicable, waived if admitted to hospital.
11. In true emergency situations, out-of-network emergency services apply to the in-network deductible and/or out-of-pocket maximum.
12. Physical, speech, spinal manipulative and occupational therapies are limited to 25 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.
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14. You have a distinct arrangement for self-administered specialty drugs. To receive benefits, you must use a Specialty Pharmacy Network provider. Visit www.bcbst.com for a list of providers in the Specialty Pharmacy Network.
    Specialty drugs are limited to a 30-day supply.
15. Copay, if applicable, applied per prescription, up to a 30 day supply.
16. 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 to find a list of pharmacies in the Plus90 Network.
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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 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 50 – 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 (55 to 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 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

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 manual 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
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  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

- 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
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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 لذكر 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 ວ່າ ການ ຊ່ວຍ ເຫລືອ ດ້ານ ພາສາ, ໂດຍ ບໍ ເສັ ຽ ຄ່າ ໃ, ແມ ນ ພ ອມ ທີ ທ່ ານ. ໂທ 1-800-565-9140 (TTY: 1-800-848-0298).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ 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 નિઃશુલ્ક 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 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).

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

5. Additional Quote Requirements for TPA/ASO & Associated Vendors

Please attach this form to the front of your proposal

ATTACHMENT TO RFP: ADMINISTRATIVE SERVICES

Third Party Administrator or ASO Provider: BlueCross BlueShield of Tennessee

Contact Information: Wayne Webb, (865) 588-4634

This form must be completed according to how administrative fees are applicable to your organization.

- *All rates should be provided as a PEPM (per employee per month) charge unless otherwise indicated.*

Quote based on recommended benefits with Traditional Pharmacy Pricing and Exclusive Specialty

Base Administration (RX04)	$33.39 PEPM
COBRA Administration	$1.00 PEPM
Utilization Review/Medical Management	Included at no additional charge
Name of UR/Case Management Organization	BlueCross BlueShield of Tennessee
Disease Management/Wellness Program Fee	$2.42 PEPM (Chronic Care Management)
PPO Administration/Coordination Fee	Included at no additional charge
PPO Access Fee	See BlueCard® PPO fees below*
Rx Administration/Coordination Fee	Included at no additional charge
Medicare Part D Notices & Testing	Not applicable
HRA Administration	$4.00 PEPM
Other Fee- - - - -	See optional services below**
TOTAL MONTHLY FEES	Based on services selected
Other Annual Fees (if applicable)	If stop loss is carved out there is an interface fee of $1.40 PEPM. If prescription drug coverage is carved out, there is an interface fee of $1.43 PEPM.
Setup (One-time fee)	None
Are on-line administrative services available?	Yes
Is a copy of your EOB included?	Yes; included as **Attachment #9**
Rate guarantees (please specify)	07/01/19 – 06/30/20

***BlueCard Fees**
The above fee includes network fees in the state of Tennessee and its contiguous counties.
For services obtained outside of the state of Tennessee and contiguous counties, all BlueCard PPO claims are subject to the following fees:

- Administration Fee of $5 per professional claim and $11 per institutional claim
- Access Fee of 4.14% of the provider savings, not to exceed $2,000 per claim.

****Optional Services**

Healthy Maternity℠	$0.46 PEPM
PhysicianNow℠ telehealth (medical only)	$0.63 PEPM
Advanced Radiological Imaging (formerly High Tech Imaging)	$1.04 PEPM
Musculoskeletal Prior Authorization	$0.85 PEPM
Genetic Testing Prior Authorization	$0.27 PEPM
Lifestyle Health Coaching	$2.88 PEPM
BlueHealth Rewards (Activate)	$1.52 PEPM
FSA Administration	$5.00 PAPM; plan set up fee and maintenance fees will apply and vary based on the number of accounts enrolled. + Accounts 1-499: $250 plan set up and $250 annual plan maintenance fee. + Accounts 500-999: $500 plan set up and $500 annual plan maintenance fee.
Self-Funded Dental Administration	$3.50 PEPM; if The County selects BlueCross for both Medical and Vision the Dental Administration fee will be reduced to $3.25 PEPM (guaranteed for three years).

Conditions
BlueCross retains the right to adjust the administrative services fee to cover reasonably anticipated cost variations resulting from:

- Changes in the Plan, Legislation or Regulation
- Termination or addition of a subsidiary, operation or class of employee
- Fluctuation of the actual number of covered employees by +/- 10% by location, state and/or in aggregate from the 328 contracts the quote was based on.

of Tennessee

Anderson County Government
Benefit Summary

Effective Date: 7/1/2019
Network: P
Option: 1 Quote: 114

Benefit Plan Features:	Your Cost In-Network	Your Cost Out-Of-Network [1]
Annual Deductible		
Individual/Family	$1000/$2000	$2000/$4000
Annual Out-of-Pocket Maximum (includes copays, coinsurance and deductibles)		
Individual/Family	$4000/$8000	$12000/$36000
4th Quarter Carry-over	Included	
Covered Services		
Preventive Care Services (see page 3 for a list)	Covered at 100%	50% after Deductible
Practitioner Office Services		
Primary Care Office Visits [2]	$35 Copay	50% after Deductible
Specialist Office Visits	$50 Copay	50% after Deductible
Office Surgery [2, 4, 5, 7]	20% after Deductible	50% after Deductible
Routine Diagnostic Lab, X-Ray & Injections	No Additional Copay	50% after Deductible
Advanced Radiological Imaging [3, 5, 8]	20% after Deductible	50% after Deductible
Provider-Administered Specialty Drugs [4]	No Additional Copay	50% after Deductible
Services Received at a Facility (includes professional and facility charges)		
Inpatient Services [3, 5]	20% after Deductible	50% after Deductible
Outpatient Surgery [4, 5, 7]	20% after Deductible	50% after Deductible
Routine Diagnostic Services - Outpatient	100% (no Deductible)	50% after Deductible
Advanced Radiological Imaging - Outpatient [3, 5, 8]	20% after Deductible	50% after Deductible
Other Outpatient Services [9]	20% after Deductible	50% after Deductible
Urgent Care Center Services	$50 Copay	50% after Deductible
Emergency Care Services [10, 11]	$500 Copay then 20% Coinsurance	$500 Copay then 20% Coinsurance
Emergency Care Advanced Radiological Imaging [8, 11]	20% after Deductible	20% after Deductible
Medical Equipment Services [4, 5]		
Durable Medical Equipment	20% after Deductible	50% after Deductible
Prosthetics 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 [3, 5]	20% after Deductible	50% after Deductible
Outpatient: Unlimited visits per annual benefit period [6]	$35 Copay	50% after Deductible
Therapeutic Services [12] (limits apply; see footnote)		
Chiropractic exam $50 Copay then 100%.	20% after Deductible	50% after Deductible
Skilled Nursing & Rehabilitation Facility Services [3, 5]		
Limited to 60 days combined per annual benefit period	20% after Deductible	50% after Deductible
Home Health Care Services [4, 5]		
Unlimited visits	20% after Deductible	50% after Deductible

Benefit Plan Features:	Your Cost In-Network	Your Cost Out-Of-Network [1]
Hospice Services		
Inpatient [3]	20% after Deductible	50% after Deductible
Outpatient	20% after Deductible	50% after Deductible
Ambulance Services [4, 5]	20% after Deductible	20% after Deductible
Prescription Drugs [4]		
Prescription Drug Out of Pocket Maximum Separate from Medical Out of Pocket Maximum	$2000 Individual $4000 Family	**Prescription Drug Out-of-Network Out of Pocket Maximum applies to Medical Out of Pocket Maximum**
Prescription Contraceptives [18]	Covered at 100%	50% after Deductible
Retail RX04 Network up to 30 day supply		
Generic [15]	$10 Copay	50% after Deductible
Preferred [15, 17]	30% with a Maximum of $125	50% after Deductible
Non-Preferred [15, 17]	30% with a Minimum of $30 and Maximum of $175	50% after Deductible
Maintenance Matters Program/Plus90 Network		
Generic [16]	$20 Copay	50% after Deductible
Preferred [16, 17]	$60 Copay	50% after Deductible
Non-Preferred [16, 17]	$80 Copay	50% after Deductible
Retail RX04 Network BCBST Preventive Drug List up to 30 day supply		
Generic [16]	$10 Copay	50% after Deductible
Preferred [16, 17]	$30 Copay	50% after Deductible
Non-Preferred [16, 17]	$40 Copay	50% after Deductible
Maintenance Matters Program/Plus90 Network		
Generic [16]	$20 Copay	50% after Deductible
Preferred [16, 17]	$60 Copay	50% after Deductible
Non-Preferred [16, 17]	$80 Copay	50% after Deductible
Self-Administered Specialty Drugs [4, 13, 14]		
Specialty Pharmacy Accredo Health Group up to 30 day supply	30% with a Minimum of $30 and Maximum of $175	Not Covered

Notes:

1. Out-of-network benefit payment based on BlueCross BlueShield of Tennessee maximum allowable charge. You are responsible for any unpaid billed charges.
2. The lower copay applies to Family Practice, General Practice, Internal Medicine, OB/GYN, Pediatrics, Behavioral Health and Health Department 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.
   Specialty drugs are limited to a 30-day supply, and only covered at 100% when administered in an office visit.
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, your liability will be increased to 50% based on out-of-network coinsurance. If services are not medically necessary, no benefits will be provided.
6. 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.
7. 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).
8. Includes CT scans, PET scans, MRIs, nuclear medicine and other similar technologies.
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    To receive benefits, you must use Accredo Health Group Phone: 1-888-239-0725 Fax: 1-866-387-1003
15. Copay, if applicable, applied per prescription, up to a 30 day supply.
16. 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 to find a list of pharmacies in the Plus90 Network.
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- One retinopathy screening for diabetics per annual benefit period

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 manual 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 hormonal contraceptives and barrier methods, sterilization for women

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- Prostate cancer screening at age 50 and older
- One-time abdominal aortic aneurysm screening at age 65 – 75 (for men who have ever smoked)

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of Tennessee

Anderson County Government
Benefit Summary

Effective Date: 7/1/2019
Network: P
Option: 2 Quote: 115

Benefit Plan Features:	Your Cost In-Network	Your Cost Out-Of-Network [1]
Annual Deductible		
Individual/Family	$1500/$3000	$3000/$6000
Annual Out-of-Pocket Maximum (includes copays, coinsurance and deductibles)		
Individual/Family	$4000/$8000	$12000/$36000
4th Quarter Carry-over	Included	
Covered Services		
Preventive Care Services (see page 3 for a list)	Covered at 100%	50% after Deductible
Practitioner Office Services		
Primary Care Office Visits [2]	$35 Copay	50% after Deductible
Specialist Office Visits	$50 Copay	50% after Deductible
Office Surgery [2, 4, 5, 7]	30% after Deductible	50% after Deductible
Routine Diagnostic Lab, X-Ray & Injections	No Additional Copay	50% after Deductible
Advanced Radiological Imaging [3, 5, 8]	30% after Deductible	50% after Deductible
Provider-Administered Specialty Drugs [4]	No Additional Copay	50% after Deductible
Services Received at a Facility (includes professional and facility charges)		
Inpatient Services [3, 5]	30% after Deductible	50% after Deductible
Outpatient Surgery [4, 5, 7]	30% after Deductible	50% after Deductible
Routine Diagnostic Services - Outpatient	100% (no Deductible)	50% after Deductible
Advanced Radiological Imaging - Outpatient [3, 5, 8]	30% after Deductible	50% after Deductible
Other Outpatient Services [9]	30% after Deductible	50% after Deductible
Urgent Care Center Services	$50 Copay	50% after Deductible
Emergency Care Services [10, 11]	30% after Deductible	30% after Deductible
Emergency Care Advanced Radiological Imaging [8, 11]	30% after Deductible	30% after Deductible
Medical Equipment Services [4, 5]		
Durable Medical Equipment	30% after Deductible	50% after Deductible
Prosthetics or Orthotics	30% after Deductible	50% after Deductible
Hearing Aids (under age 18)	30% after Deductible	50% after Deductible
Behavioral Health Services		
Inpatient: Unlimited days per annual benefit period [3, 5]	30% after Deductible	50% after Deductible
Outpatient: Unlimited visits per annual benefit period [6]	$35 Copay	50% after Deductible
Therapeutic Services [12] (limits apply; see footnote)		
Chiropractic exam $50 Copay then 100%.	30% after Deductible	50% after Deductible
Skilled Nursing & Rehabilitation Facility Services [3, 5]		
Limited to 60 days combined per annual benefit period	30% after Deductible	50% after Deductible
Home Health Care Services [4, 5]		
Unlimited visits	30% after Deductible	50% after Deductible

Benefit Plan Features:	Your Cost In-Network	Your Cost Out-Of-Network [1]
Hospice Services		
Inpatient [3]	30% after Deductible	50% after Deductible
Outpatient	30% after Deductible	50% after Deductible
Ambulance Services [4, 5]	30% after Deductible	30% after Deductible
Prescription Drugs [4]		
Prescription Drug Out of Pocket Maximum Separate from Medical Out of Pocket Maximum	$2000 Individual $4000 Family	**Prescription Drug Out-of-Network Out of Pocket Maximum applies to Medical Out of Pocket Maximum**
Prescription Contraceptives [18]	Covered at 100%	50% after Deductible
Retail RX04 Network up to 30 day supply		
Generic [15]	$10 Copay	50% after Deductible
Preferred [15, 17]	30% with a Maximum of $125	50% after Deductible
Non-Preferred [15, 17]	30% with a Minimum of $30 and Maximum of $175	50% after Deductible
Maintenance Matters Program/Plus90 Network		
Generic [16]	$20 Copay	50% after Deductible
Preferred [16, 17]	$60 Copay	50% after Deductible
Non-Preferred [16, 17]	$80 Copay	50% after Deductible
Retail RX04 Network BCBST Preventive Drug List up to 30 day supply		
Generic [16]	$10 Copay	50% after Deductible
Preferred [16, 17]	$30 Copay	50% after Deductible
Non-Preferred [16, 17]	$40 Copay	50% after Deductible
Maintenance Matters Program/Plus90 Network		
Generic [16]	$20 Copay	50% after Deductible
Preferred [16, 17]	$60 Copay	50% after Deductible
Non-Preferred [16, 17]	$80 Copay	50% after Deductible
Self-Administered Specialty Drugs [4, 13, 14]		
Specialty Pharmacy Accredo Health Group up to 30 day supply	30% with a Minimum of $30 and Maximum of $175	Not Covered

Notes:

1. Out-of-network benefit payment based on BlueCross BlueShield of Tennessee maximum allowable charge. You are responsible for any unpaid billed charges.
2. The lower copay applies to Family Practice, General Practice, Internal Medicine, OB/GYN, Pediatrics, Behavioral Health and Health Department 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.
   Specialty drugs are limited to a 30-day supply, and only covered at 100% when administered in an office visit.
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, your liability will be increased by 10% based on out-of-network coinsurance. If services are not medically necessary, no benefits will be provided.
6. 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.
7. 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).
8. Includes CT scans, PET scans, MRIs, nuclear medicine and other similar technologies.
9. Includes services such as chemotherapy, infusions, injections, radiation therapy and renal dialysis.
10. Copay, if applicable, waived if admitted to hospital.
11. In true emergency situations, out-of-network emergency services apply to the in-network deductible and/or out-of-pocket maximum.
12. Physical, speech, spinal manipulative and occupational therapies are limited to 25 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.
13. Visit www.bcbst.com for the Preferred Formulary which includes specialty drugs and preventive drug list.
14. You have a distinct arrangement for self-administered specialty drugs. Specialty drugs are limited to a 30-day supply.
    To receive benefits, you must use Accredo Health Group Phone: 1-888-239-0725 Fax: 1-866-387-1003
15. Copay, if applicable, applied per prescription, up to a 30 day supply.
16. 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 to find a list of pharmacies in the Plus90 Network.
17. 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.
18. 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 for the Preferred Formulary.

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 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 50 – 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 (55 to 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 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

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 manual 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 hormonal contraceptives and barrier methods, sterilization for women

  Rx plan: Generic oral & injectable contraceptives, vaginal contraceptive, patch, prescription emergency contraception

- 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

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