Non-EHB Medical Prospect Benefit Summary

Group: School Facility Management, LLC **Quote:** 00431264

Plan Information

Plan Name: INT-LF, HDHP ($5000 Embedded/$7000 Embedded/50%) (HSA Qualified) S Network

Network: Blue Network S

Benefit Effective Date: 1/1/2026

Effective Date: 1/1/2026

Benefit Plan Features	Cost In-Network	Cost Out-of-Network [1]
Annual Deductible		
Individual / Family	$5,000 / $10,000	$10,000 / $20,000
Annual Out-of-Pocket Maximum (includes copays, coinsurance and deductibles)		
Individual / Family	$7,000 / $14,000	$21,000 / $42,000
Covered Services		
Preventive Care Services [13]	Covered at 100%	50% after Deductible
Practitioner Office Services		
Primary Care Office Visits	50% after Deductible	50% after Deductible
Specialist Office Visits	50% after Deductible	50% after Deductible
Office Surgery [4, 5, 6]	50% after Deductible	50% after Deductible
Advanced Radiological Imaging [3, 5, 7]	50% after Deductible	50% after Deductible
Teladoc Health® Virtual Care	$0 Copay	Not Covered
Services Rendered at a Facility (includes professional and facility charges)		
Inpatient Services [3, 5]	50% after Deductible	50% after Deductible
Outpatient Surgery [4, 5, 6]	50% after Deductible	50% after Deductible
Routine Diagnostic Services – Outpatient	50% after Deductible	50% after Deductible
Advanced Radiological Imaging – Outpatient [3, 5, 7]	50% after Deductible	50% after Deductible
Other Outpatient Services [8]	50% after Deductible	50% after Deductible
Urgent Care Center Services	50% after Deductible	50% after Deductible
Emergency Care Services [10]	50% after Deductible	50% after Deductible
Emergency Care Advanced Radiological Imaging [7]	50% after Deductible	50% after Deductible
Skilled Nursing & Rehabilitation Facility Services [3, 5]		
Limited to 60 days combined per annual benefit period	50% after Deductible	50% after Deductible
Medical Equipment [4, 5]		
Durable Medical Equipment	50% after Deductible	50% after Deductible
Prosthetics & Orthotics	50% after Deductible	50% after Deductible
Hearing Aids (under age 18) [20]	50% after Deductible	50% after Deductible
Behavioral Health Services (Unlimited days per annual benefit period)		
Inpatient [3, 5]	50% after Deductible	50% after Deductible
Outpatient [14]	50% after Deductible	50% after Deductible
Therapeutic Services [4, 5, 9]		
Rehabilitative	50% after Deductible	50% after Deductible
Home Health Services [4, 5, 9]		
Home Health Care Services	50% after Deductible	50% after Deductible
Hospice Services [5, 21]		

Hospice Services	50% after Deductible	50% after Deductible
Ambulance Services [4]		
Ambulance Services	50% after Deductible	50% after Deductible
Prescription Drugs [4, 11, 12, 16, 19]		
Prescription Contraceptives [16]	Covered at 100%	50% after Deductible
Retail Network, Plus90, or Home Delivery Network [15]		
Preferred Generic	50% after Deductible	50% after Deductible
Non-Preferred Generic	50% after Deductible	50% after Deductible
Preferred Brand	50% after Deductible	50% after Deductible
Non-Preferred Brand	50% after Deductible	50% after Deductible
Preventive Drugs [15, 18]		
Generic	$10 Copay	50% after Deductible
Preferred	$35 Copay	50% after Deductible
Non-Preferred	$60 Copay	50% after Deductible
Self-Administered Specialty Drugs [17]		
Specialty Pharmacy Network		
Preferred Specialty	50% after Deductible	Not Covered
Non-Preferred Specialty	50% after Deductible	Not Covered
Provider-Administered Specialty Drugs [4, 17]		
Specialty Pharmacy Network	50% after Deductible	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 60%. 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 40 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 Preferred 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 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/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 Preferred Formulary.
17. You have a distinct network for self-administered specialty drugs and provider-administered specialty drugs. To receive benefits, you must use a Specialty Pharmacy Network provider. Visit www.bcbst.com/rx for a list of providers in the Specialty Pharmacy Network. Self-administered specialty drugs are limited to a 30 day supply.
18. 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 Preferred Formulary.
19. 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.
20. Limited to 1 per ear every 3 years.
21. Inpatient Hospice requires prior authorization.

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.

of Tennessee

Summary of Preventive Care Services Covered at 100%

Group: School Facility Management, LLC **Quote:** 00431264

Plan Information

Plan Name: INT-LF, HDHP ($5000 Embedded/$7000 Embedded/50%) (HSA Qualified) S Network

In-network preventive care services that are covered with no member cost share include, but are not limited to:

- Primary care services with an A or B recommendation by the United States Preventive Services Task Force (USPSTF)
- Immunizations recommended by the Advisory Committee on Immunization Practices that have been adopted by the Centers for Disease Control and Prevention (CDC)
- Bright Futures recommendations for infants, children and adolescents that are supported by the Health Resources and Services Administration (HRSA)
- Preventive care and screening for women as provided in the guidelines supported by HRSA

The following preventive care services are covered (not an all-inclusive list). Coverage of some services may depend on age and/or risk exposure.

All Members:

- One preventive health exam per annual benefit period; more frequent preventive exams are covered for children up to age 3
- All standard immunizations adopted by the CDC
- Screening for colorectal cancer (age 45 – 75), high cholesterol and lipids (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 as deemed clinically appropriate by USPSTF and HRSA guidelines
- 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 as deemed clinically appropriate by USPSTF and HRSA guidelines
- 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
- 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

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[1]. BlueCross does not exclude people or treat them less favorably because of race, color, national origin, age, disability or sex.

BlueCross:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as: (1) qualified sign language interpreters and (2) written information in other formats, such as large print, audio and accessible electronic formats.
- Provides free language assistance services to people whose primary language is not English, such as: (1) qualified interpreters and (2) information written in other languages.

If you need these reasonable modifications, appropriate auxiliary aids and services, or language assistance 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 Grievance; 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.

You can contact BlueCross's Nondiscrimination Coordinator at 423-535-1010 (TTY: 1-800-848-0298 or 711); Nondiscrimination_CoordinatorGM@bcbst.com (email); or Corporate Compliance, 1 Cameron Hill Circle, 1.4, Chattanooga, TN 37402.

This notice is available at BlueCross's website: bcbst.com.

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.

[1] Consistent with the scope of sex discrimination described at 45 CFR 92.101(a)(2))

ATTENTION: If you speak English, free language assistance services and appropriate auxiliary aids and services are available to you. Please call the Member Service number on the back of your Member ID card or 1-800-565-9140 (TTY: 1-800-848-0298).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma, así como ayudas y servicios auxiliares adecuados. Llame al número de Servicio de atención a miembros que figura en el reverso de su tarjeta de identificación de miembro o al 1-800-565-9140 (TTY: 1-800-848-0298).

انتباه: إذا كنت تتحدث العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية والخدمات والأدوات المساعدة المناسبة. يرجى الاتصال برقم خدمة الأعضاء الموجود على ظهر بطاقة هوية العضو الخاص بك أو بالرقم (الهاتف النصي: 1-800-848-0298) 1-800-565-9140

注意：如果您說中文，我們提供免費的語言協助服務，以及適當的輔助協助和服務。請撥打會員 ID 卡背面的會員服務部號碼或 1-800-565-9140（聽障專線 (TTY)：1-800-848-0298）。

LƯU Ý: Nếu quý vị nói tiếng Việt, quý vị sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí và các dịch vụ và công cụ hỗ trợ phù hợp. Vui lòng gọi đến số của bộ phận Dịch vụ Hội viên ở mặt sau Thẻ ID Thành viên của quý vị hoặc số 1-800-565-9140 (TTY: 1-800-848-0298).

주의: [한국어]를 사용하시는 경우, 무료 언어 지원 서비스 및 적절한 보조 기구와 서비스가 제공됩니다. 가입자 ID 카드 뒷면의 가입자 서비스 전화번호 또는 1-800-565-9140(TTY: 1-800-848-0298)번으로 전화하시기 바랍니다.

ATTENTION : Si vous parlez français, des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés sont à votre disposition. Veuillez appeler le numéro du Service adhérents indiqué au dos de votre carte d'assuré adhérent ou le 1-800-565-9140 (TTY/ATS : 1-800-848-0298).

เอาใจใส่: ถ้าท่านเว้าพาสา พาสาลาว, มีการบໍລิการ ช่วยเหຼือด้านพาสา และ การช่วยเหຼือ และ การบໍລิการที่เพาะสົ่มให้ท่าน. กะลุนาโทพาเบิ๊ดของฝ่ายบໍລิการสะมาชิก ที่มีอยู่ด้านหຼังบัด ID สะมาชิกของท่าน ห 1-800-565-9140 (TTY: 1-800-848-0298).

ማስገንዘቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ረዳት መርጃዎች እና አገልግሎቶች ለእርስዎ ይገኛሉ። በአባልነት መታወቂያዎ ጀርባ ላይ በሚገኘው የአባላት አገልግሎት ቁጥር ወይም በ 1-800-565-9140 (TTY: 1-800-848-0298) ይደውሉ።

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste und geeignete Hilfsmittel und Dienstleistungen zur Verfügung. Bitte rufen Sie die Nummer des Mitgliederdienstes auf der Rückseite Ihrer Mitglieds-ID-Karte oder 1-800-565-9140 (TTY: 1-800-848-0298) an.

ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારા માટે નિ:શુલ્ક ભાષા સહાય સેવાઓ અને યોગ્ય સહાયક સાધનો અને સેવાઓ ઉપલબ્ધ છે. કૃપા કરીને તમારા સભ્ય ID કાર્ડની પાછળના સભ્ય સર્વિસ નંબર ઉપર અથવા 1-800-565-9140 (TTY: 1-800-848-0298) પર કૉલ કરો.

お知らせ：日本語をお話しになる場合は、無料の支援サービスと適切な補助器具・サービスがご利用いただけます。会員IDカードの裏面に記載の会員サービス番号あるいは1-800-565-9140 (TTY: 1-800-848-0298)まで、お電話にてご連絡ください。

PANSININ: Kung kayo ay nagsasalita ng Tagalog, available para sa inyo ang libreng mga serbisyong tulong sa wika at kaukulang mga auxiliary aid at mga serbisyo. Mangyaring tawagan ang numero ng Serbisyo sa Miyembro na nasa likod ng inyong Kard ng ID ng Miyembro o sa 1-800-565-9140 (TTY: 1-800-848-0298).

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए नि:शुल्क भाषा सहायता सेवाएँ और उपयुक्त सहायक साधन और सेवाएँ उपलब्ध हैं। कृपया अपने सदस्य ID कार्ड के पीछे दिए गए सदस्य सेवा नंबर या 1-800-565-9140 (TTY: 1-800-848-0298) पर कॉल करें।

ВНИМАНИЕ! Если Вы говорите по-русски, Вам будут предоставлены услуги языковой поддержки и соответствующие вспомогательные средства и сервисы на бесплатной основе. Позвоните в отдел обслуживания участников по номеру, указанному на обратной стороне Вашей идентификационной карты участника, или по номеру 1-800-565-9140 (TTY: 1-800-848-0298).

توجه: اگر به زبان فارسی صحبت می کنید، خدمات کمک زبانی رایگان و مساعدت ها و خدمات کمکی مناسب در دسترس شما هستند. درصورتیکه عضو هستید، با شماره خدمات اعضا در پشت کارت عضویت خود یا 1-800-565-9140 (TTY: 1-800-848-0298) تماس بگیرید.

ATANSYON: Si w pale Kreyòl Ayisyen, genyen sèvis asistans gratis pou lang ansanm ak èd pou sèvis oksilyè apwopriye k ap disponib pou ou. Tanpri rele nimewo Sèvis Manm ki sou do kat ID Manm ou an oswa 1-800-565-9140 (TTY: 1-800-848-0298).

UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej oraz rozwiązań i usług pomocniczych. Prosimy zadzwonić pod numer działu obsługi ubezpieczonych podany na odwrocie karty identyfikacyjnej członka lub numer 1-800-565-9140 (TTY: 1-800-848-0298).

ATENÇÃO: Se você fala Português, serviços gratuitos de assistência linguística e recursos e serviços auxiliares apropriados estão disponíveis para você. Ligue para o número de telefone do serviço de Atendimento ao Membro informado no verso de seu cartão de identificação de membro ou para 1-800-565-9140 (TTY: 1-800-848-0298).

ATTENZIONE: se parla italiano, sono disponibili per Lei servizi gratuiti di assistenza linguistica nonché aiuti e servizi ausiliari adeguati. Chiami il numero del Servizio per i membri riportato sul retro della Sua scheda identificativa del membro oppure il numero 1-800-565-9140 (TTY: 1-800-848-0298).

BAA'áKOHWIINIDZIN: Diné bizaad bee yáníłti'go, t'áá jiik'eh saad bee áka'anáʼawo' bee áka'anída'awo'í dóó t'áadoole'é binahjí' bee adahodooníłígíí diné bich'į' anídahazt'i'í bee bika'aanída'awo'í ná dahóló. T'áá shóódí Bił Ha'dít'éhí Bika'anáʼawo' Bił Ha'dít'éhí ID naaltsoos nitł'izí bine'dęę' binámboo bee hodíilnih doodago 1-800-565-9140 (TTY: 1-800-848-0298).

WICHDICH: Wann du Deitsch schwetzscht un brauchscht Hilf fer communicat-e kenne mer dich helfe unni as es dich ennich eppes koschde zellt. Mir kenne differnti Sadde Schprooch-Hilf beigriege aa fer nix. Ruf der Member Service Number uff die hinnerscht Seit vun dei Member ID Card uff odder 1-800-565-9140 (TTY: 1-800-848-0298).

FAASILASILAGA: Afai e te tautala i le faa-Samoa, o loo avanoa mo oe auaunaga fesoasoani mo gagana e aunoa ma se totogi faapea ma fesoasoani fa'aopo'opo ma auaunaga talafeagai. Faamolemole vala'au le numera o le Member Service (Auaunaga mo Tagata Auai) o lo'o i tua o lau pepa ID o le Member (Tagata Auai) po o le 1-800-565-9140 (TTY: 1-800-848-0298).

GAKIULA: Gare iga go kapetal Faluwasch, ye toore paliuwal yamem bwe tepangug rel gamatefal lane kapetal Faluwasch. Fale peshem kol yegili nampal Member Service ila yelog liugul tagurul Member ID kard la yam gare 1-800-565-9140 (TTY: 1-800-848-0298).

ATENSION: Guaha setbisio siha para hâgu yanggen fifino' CHamoru hao, dibâtde na setbision inayudon fumino' CHamoru yan propriu na inasisten tråstes yan setbisio siha. Put fabot âgang i numiron Setbision Membro gi santatten i kattå-mu Member ID pat 1-800-565-9140 (TTY: 1-800-848-0298).