BlueCross BlueShield of Tennessee

Co-op Health and Welfare Plan and Trust
Option 3 Minimum Value Plan - Employee Only
Effective Date: 1/1/2025

Benefit Features	Network Providers	Out-of-Network Providers [1]
Annual Deductible		
Employee Only Coverage	$4,000	$8,000
Annual Out-of-Pocket Maximum Amount		
Employee Only Coverage	$6,500	$13,000
Lifetime Maximum Benefit	Unlimited	
Pre-Existing Waiting Period	None	
4th Quarter Deductible Carryover Provision	Not Included	
Benefits for Covered Services	**In-Network Benefits**	**Out-of-network Benefits** [1]
Practitioner Office Services		
Office Visits (including Office Surgery)	60% after Deductible	40% after Deductible
Routine Diagnostic Lab, X-Ray, & Injections	60% after Deductible	40% after Deductible
Advanced Radiological Imaging [4]	60% after Deductible	40% after Deductible
Preventive Health Care Services		
Well Child Care (under age 6)	100%	40% after Deductible
Well Care (age 6 and up)	100%	40% after Deductible
Annual Well Woman Exam	100%	40% after Deductible
Annual Mammography Screening	100%	40% after Deductible
Annual Cervical Cancer Screening	100%	40% after Deductible
Annual Prostate Cancer Screening	100%	40% after Deductible
Immunizations	100%	40% after Deductible
Services Received at a Facility (includes professional and facility charges)		
Inpatient Services [2]	60% after Deductible	40% after Deductible
Outpatient Surgery [3]	60% after Deductible	40% after Deductible
Routine Diagnostic Services-Outpatient	60% after Deductible	40% after Deductible
Advanced Radiological Imaging-Outpatient [4]	60% after Deductible	40% after Deductible
Other Outpatient Services [5]	60% after Deductible	40% after Deductible
Emergency Care Services	60% after Deductible	60% after Deductible
Medical Equipment		
Durable Medical Equipment, Prosthetic and Orthotic Appliances	60% after Deductible	40% after Deductible
Chiropractor Services		
Manipulative Therapy is limited to 20 visits per year	60% after Deductible	40% after Deductible
Therapeutic Services (6)		
Therapy (Limited to 30-36 visits per year per therapy type)	60% after Deductible	40% after Deductible
Skilled Nursing Facility & Rehabilitation Facility Services [2]		
Limited to 60 days combined	60% after Deductible	40% after Deductible
Home Health Services [7]	60% after Deductible	40% after Deductible
Hospice Services	60% after Deductible	40% after Deductible
Ambulance Service	60% after Deductible	60% 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 for certain services received from out-of-network providers. For true emergency services received at an out-of-network hospital, items and services received from an out-of-network provider at an in-network hospital (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. Services require prior authorization. Benefits will be reduced to 30% for services received from network providers outside Tennessee and all out-of-network providers when prior authorization not obtained.
3. Surgeries include invasive diagnostic procedures such as colonoscopy and sigmoidoscopy.
4. CAT scans, MRIs, nuclear medicine and other similar technologies.
5. Includes services such as chemotherapy, radiation therapy, infusions, and renal dialysis.
6. Physical, speech and occupational therapies are limited to 30 visits per therapy type per year. Cardiac and Pulmonary Rehabilitative therapies are limited to 36 visits per therapy type per year.
7. Requires prior authorization.