



City of Columbia

Effective Date: Jul 1, 2024

Network: S

Option/Quote: 1/373

Benefit Summary

Benefit Plan Features:	Your Cost In-Network	Your Cost Out-of-Network ¹
Annual Deductible		
Individual/Family	\$1,000 / \$2,000	\$2,000 / \$4,000
Annual Out-of-Pocket Maximum (includes copay, coinsurance and deductibles)		
Individual/Family	\$3,000 / \$6,000	\$9,000 / \$18,000
4th Quarter Carry-over		Excluded
Covered Services		
Preventive Care Services (see page 3 for a list)	Covered at 100%	40% after deductible
Practitioner Office Services		
Primary Care Office Visits	20% after deductible	40% after deductible
Specialist Office Visits	20% after deductible	40% after deductible
Office Surgery ^{3, 4, 6}	20% after deductible	40% after deductible
Routine Diagnostic Lab, X-Ray & Injections	20% after deductible	40% after deductible
Advanced Radiological Imaging ^{2, 4, 7}	20% after deductible	40% after deductible
Services Received at a Facility (includes professional and facility charges)		
Inpatient Services ^{2, 4}	20% after deductible	40% after deductible
Outpatient Surgery ^{3, 4, 6}	20% after deductible	40% after deductible
Routine Diagnostic Services - Outpatient	20% after deductible	40% after deductible
Advanced Radiological Imaging - Outpatient ^{2, 4, 7}	20% after deductible	40% after deductible
Other Outpatient Services ⁸	20% after deductible	40% after deductible
Emergency Care Services ⁹	20% after deductible	20% after deductible
Emergency Care Advanced Radiological Imaging ⁷	20% after deductible	20% after deductible
Medical Equipment Services ^{3, 4}		
Durable Medical Equipment	20% after deductible	40% after deductible
Prosthetic or Orthotics	20% after deductible	40% after deductible
Hearing Aids (under age 18)	20% after deductible	40% after deductible
Behavioral Health Services		
Inpatient: Unlimited days per annual benefit period ^{2, 4}	20% after deductible	40% after deductible
Outpatient: Unlimited visits per annual benefit period ⁵	20% after deductible	40% after deductible
Therapeutic Services ¹⁰ (limits apply; see footnote)	20% after deductible	40% after deductible
Skilled Nursing & Rehabilitation Facility Services ^{2, 4}		
Limited to 60 days combined per annual benefit period	20% after deductible	40% after deductible
Home Health Care Services ^{3, 4, 10} (Limited to 60 visits per annual benefit period)	20% after deductible	40% after deductible
Hospice Services		
Inpatient ^{2, 4}	Covered at 100%	40% after deductible
Outpatient	Covered at 100%	40% after deductible
Ambulance Services ^{3, 4}	20% after deductible	20% after deductible
Provider-Administered Specialty Drugs ^{3, 21}	\$100 copay	Not Covered

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. 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 coinsurance. 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. Physical, speech, spinal manipulative and occupational therapies are limited to 30 visits per therapy type per annual benefit period. Cardiac and pulmonary rehabilitative therapies are limited to 36 visits per therapy type per annual benefit period.
21. To receive benefits for provider-administered specialty drugs as identified on the provider-administered specialty drug list, you must use a Specialty Pharmacy Network provider. Visit www.bcbst.com/rx for the drug list and a list of providers in this network. Cost share listed is for the medication only; providers may bill additional charges for the administering of the drug under your medical benefit.

[Limitations and Exclusions](#). These pages summarize your health care plan benefits. Your Evidence of Coverage (EOC) defines the full terms and conditions, limitations, and exclusions in greater detail. Should any questions arise concerning benefits, the EOC will govern.

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 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 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
- 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 & supplies, including lactation support services and counseling by a trained provider and one 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 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 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

