Nashville Musicians Association AFM, Local 257

Effective Date: 1/1/2018

Network: P

Benefit Summary

PPO $6000 Ded / Quote 44

Benefit Plan Features:	Your Cost In-Network	Your Cost Out-Of-Network [1]
Annual Deductible		
Individual/Family	$6000/$12000	$12000/$24000
Annual Out-of-Pocket Maximum		
Individual/Family	$7350/$14700	$22050 / $40000
4th Quarter Carry-over	Excluded	
Covered Services		
Preventive Care Services (see page 3 for a list)		
Well Child Care Services	Covered at 100%	40% after Deductible
Well Care Services	Covered at 100%	40% after Deductible
Annual Well Women Exam, Mammogram	Covered at 100%	40% after Deductible
Practitioner Office Services		
Primary Care Office Visits [2]	$50 Copay	40% after Deductible
Specialist Office Visits	$75 Copay	40% after Deductible
Office Surgery [2, 4, 5, 7]	$50 Copay or $75 Copay	40% after Deductible
Routine Diagnostic Lab, X-Ray & Injections	No Additional Copay	40% after Deductible
Advanced Radiological Imaging [3, 5, 8]	20% after Deductible	40% after Deductible
Provider-Administered Specialty Drugs [4]	$120 Copay	40% after Deductible
Services Received at a Facility (includes professional and facility charges)		
Inpatient Services [3, 5]	20% after Deductible	40% after Deductible
Outpatient Surgery [4, 5, 7]	20% after Deductible	40% after Deductible
Routine Diagnostic Services - Outpatient	100% (no Deductible)	40% after Deductible
Advanced Radiological Imaging - Outpatient [3, 5, 8]	20% after Deductible	40% after Deductible
Other Outpatient Services [9]	20% after Deductible	40% after Deductible
Emergency Care Services [10, 11]	$350 Copay	$350 Copay
Emergency Care Advanced Radiological Imaging [8, 11]	20% after Deductible	20% after Deductible
Medical Equipment [4]		
Durable Medical Equipment	20% after Deductible	40% after Deductible
Prosthetics	20% after Deductible	40% after Deductible
Orthotic Appliances	20% after Deductible	40% after Deductible
Hearing Aids (under age 18)	20% after Deductible	40% after Deductible
Behavioral Health		
Inpatient: Unlimited days per annual benefit period [3, 5]	20% after Deductible	40% after Deductible
Outpatient: Unlimited visits per annual benefit period [6]	$50 Copay	40% after Deductible
Therapy Services [12] (limits apply; see footnote)	$50 Copay	40% after Deductible
Skilled Nursing Facility & Rehabilitation Facility Services [3, 5]		
Limited to 60 days combined per annual benefit period	20% after Deductible	40% after Deductible
Home Health Care Services [4, 5]		
Limited to 60 visits per annual benefit period	20% after Deductible	40% after Deductible

BlueCross BlueShield of Tennessee, Inc., an independent Licensee of the BlueCross BlueShield Association

Benefit Plan Features:	Your Cost In-Network	Your Cost Out-Of-Network [1]
Hospice Services		
Inpatient [3]	Covered at 100%	40% after Deductible
Outpatient	Covered at 100%	40% after Deductible
Ambulance Service [4]	20% after Deductible	20% after Deductible
Prescription Drugs [4]		
Prescription Contraceptives [18]	Covered at 100%	40% after Deductible
Retail RX04 Network up to 30 day supply		
Generic [15]	$20.00	40% after Deductible
Preferred [15, 17]	$40.00	40% after Deductible
Non-Preferred [15, 17]	$60.00	40% after Deductible
Plus90 or Home Delivery Network up to 90 day supply		
Generic [16]	$40.00	40% after Deductible
Preferred [16, 17]	$80.00	40% after Deductible
Non-Preferred [16, 17]	$120.00	40% after Deductible
Self-Administered Specialty Drugs [4, 13, 14]		
Specialty Pharmacy Network - up to 30 day supply	$120.00	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 charge.
2. The lower copay applies to Family Practice, General Practice, Internal Medicine, OB/Gyn, Pediatrics, Nurse Practitioners and Physician Assistants.
3. Requires prior authorization.
4. Certain procedures, services, medication and equipment may require prior authorization.
5. If prior authorization is required, when using network providers outside Tennessee for physician and outpatient services and all services from out-of-network providers, benefits will be reduced by 10% based on out-of-network coinsurance if prior authorization is not obtained and services are medically necessary. 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., non-screening colonoscopy, sigmoidoscopy and endoscopy).
8. 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 Refer to the *Services Received at a Facility* section for applicable benefits related to the non-emergency use of emergency care services.
12. 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.
13. Visit www.bcbst.com for the Preferred Formulary which includes specialty drugs.
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 per prescription, up to 30 day supply (when copays apply).
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. This plan covers the following at 100%, in accordance with the Women's Preventive Services provision of the Affordable Care Act: generic contraceptives, vaginal ring, hormonal patch and emergency contraception available with a prescription. Visit www.bcbst.com for the Preferred Formulary which includes prescription contraceptives.

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 Health Services
Covered at 100% In-Network

In-network preventive services that are covered with no cost share include:

- 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

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