



Highland Ventures, LTD

Effective Date: Jan 1, 2024

Network: P

SLX: 14

Benefit Summary

PPO Option: 1

Benefit Plan Features:	Your Cost In-Network	Your Cost Out-of-Network ¹
Annual Deductible Individual/Family	\$1,000 / \$3,000	\$2,000 / \$6,000
Annual Out-of-Pocket Maximum (includes copay, coinsurance and deductibles) Individual/Family	\$3,000 / \$9,000	\$8,000 / \$24,000
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 Specialist Office Visits Office Surgery ^{3, 4, 6, 20} Routine Diagnostic Lab, X-Ray & Injections Advanced Radiological Imaging ^{2, 4, 7}	\$40 copay \$60 copay 20% after deductible No Additional Copay 20% after deductible	40% after deductible 40% after deductible 40% after deductible 40% after deductible 40% after deductible
Services Received at a Facility (includes professional and facility charges) Inpatient Services ^{2, 4} Outpatient Surgery ^{3, 4, 6} Routine Diagnostic Services - Outpatient Advanced Radiological Imaging - Outpatient ^{2, 4, 7} Other Outpatient Services ⁸ Urgent Care Center Services Emergency Care Services ⁹ Emergency Care Advanced Radiological Imaging ⁷	20% after deductible 20% after deductible Covered at 100% 20% after deductible 20% after deductible 20% after deductible \$300 copay 20% after deductible	40% after deductible 40% after deductible 40% after deductible 40% after deductible 40% after deductible 40% after deductible \$300 copay 20% after deductible
Medical Equipment Services ^{3, 4} Durable Medical Equipment Prosthetic or Orthotics	20% after deductible 20% after deductible	40% after deductible 40% after deductible
Behavioral Health Services Inpatient: Unlimited days per annual benefit period ^{2, 4} Outpatient: Unlimited visits per annual benefit period ⁵	20% after deductible \$40 copay	40% 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}	20% after deductible	40% after deductible
Hospice Services Inpatient ^{2, 4} Outpatient	20% after deductible 20% after deductible	40% after deductible 40% after deductible
Ambulance Services ^{3, 4}	20% after deductible	20% after deductible
Prescription Drugs ³		
Pharmacy Only Out-of-Pocket Maximum	\$1,000 Individual / \$3,000 Family	
Prescription Contraceptives ¹⁶	Covered at 100%	40% after deductible
Retail RX04 Network up to 30 day supply ¹³ Preferred Generic Non-Preferred Generic Preferred Brand ¹⁵ Non-Preferred Brand ¹⁵	\$15 copay \$15 copay \$30 copay \$50 copay	40% after deductible 40% after deductible 40% after deductible 40% after deductible

Plus90 or Home Delivery Network up to 90 day supply ¹⁴		
Preferred Generic	\$30 copay	40% after deductible
Non-Preferred Generic	\$30 copay	40% after deductible
Preferred Brand ¹⁵	\$60 copay	40% after deductible
Non-Preferred Brand ¹⁵	\$100 copay	40% after deductible
Self-Administered Specialty Drugs ^{3, 11, 12}		
Preferred Specialty Drugs	\$50 copay	Not Covered
Non-Preferred Specialty Drugs	\$50 copay	Not Covered
Provider-Administered Specialty Drugs ^{3, 23}	\$50 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, occupational, cardiac rehabilitative and pulmonary rehabilitative therapies unlimited visits per annual benefit period. Chiropractic limited to 30 visits per annual benefit period.

11. Visit www.bcbst.com/rx for the Preferred Formulary which includes specialty drugs.

12. You must use one of the Specialty Pharmacy Network providers listed on www.bcbst.com/rx to receive benefits for self-administered specialty drugs, and these drugs are limited to a 30-day supply.

13. Copay, if applicable, applied per prescription, up to a 30 day supply.

14. 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.

15. 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.

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 with an "ACA" indicator on the Preferred Formulary located at www.bcbst.com/rx.

20. 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.

23. 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. Cover treatment of all infertility services.
- 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

Dii baa akó nínízin: Dii saad bee yańilti'go Diné Bizaad, saad bee
 áká'anida'áwo'déé', t'aa jiik'eh, ei ná hólo, koji' hódíilnih 1-800-565-9140
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