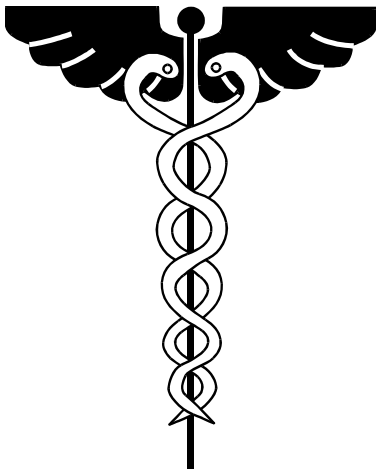
Clarksville – Montgomery County Employees Insurance Trust

Health Benefit Plan Summary of Material Modification



1-1-2018

NOTICE

PLEASE READ THIS SUMMARY OF MATERIAL MODIFICATION (SMM) CAREFULLY AND KEEP IT IN A SAFE PLACE FOR FUTURE REFERENCE. IT EXPLAINS YOUR BENEFITS AS ADMINISTERED BY BLUECROSS BLUESHIELD OF TENNESSEE, INC. THIS SMM IS EFFECTIVE JANUARY 1, 2018.

THE ACTIVE STANDARD EOC YOU RECEIVED IS MODIFIED BY:

1. In the **Schedule of Benefits** under the heading **DEDUCTIBLE**, the following has been modified and reads as follows:

DEDUCTIBLE

Deductible to be applied to:	**Network Provider**	**Out-of-Network Provider**
Individual Deductible Maximum	$2,000	$2,000
Two-Person Deductible Maximum	$4,000	$4,000
Family Deductible Maximum	$5,000	$5,000

Combined - Network/ Out-of-Network Deductibles:	
Individual	$2,000
Two-Person	$4,000
Family	$5,000

2. In the **Schedule of Benefits** under the heading **COINSURANCE**, the following has been modified and reads as follows:

COINSURANCE:

Coinsurance percentages will be applied to the lesser of the negotiated fee or other basis for Our reimbursement for Covered Services**.**

Benefits available for Covered Services received from an Out-of-Network Provider will be significantly less than benefits available for services received from a Network Provider. For services received from an Out-of-Network Provider, the Member must pay the applicable Coinsurance, as well as the difference between the Out-of-Network Provider's Billed Charges and the Maximum Allowable Charge.

Coinsurance to be applied to:	**Network Provider**	**Out-of-Network Provider**
All Covered Services after Deductible has been satisfied (unless otherwise specified)	70%	50% of the Maximum Allowable Charge
Skilled Nursing Facility and Rehabilitation Services, limited to 100 days per Annual Benefit Period.	70%	50% of the Maximum Allowable Charge
Preventive Services Under age 6	100%	50% of the Maximum Allowable Charge after Deductible has been satisfied

Coinsurance to be applied to:	Network Provider	Out-of-Network Provider
Preventive Services Age 6 and over Includes preventive health exam, screenings and counseling services. Alcohol misuse and tobacco use counseling limited to 8 visits annually; must be provided in the primary care setting; Dietary counseling for adults with hyperlipidemia, hypertension, Type 2 diabetes, coronary artery disease and congestive heart failure limited to 12 visits annually.	100%	50% of the Maximum Allowable Charge after Deductible has been satisfied
Lactation counseling by a trained provider during pregnancy or in the post-partum period. Limited to one visit per pregnancy.	100%	50% of the Maximum Allowable Charge after Deductible
Manual and Electric Breast Pump, limited to one per pregnancy	100%	50% of the Maximum Allowable Charge after Deductible
FDA-approved contraceptive methods, sterilization procedures and counseling for women with reproductive capacity.	100%	50% of the Maximum Allowable Charge after Deductible
One (1) retinopathy screening for diabetics per Annual Benefit Period	100%	Not Covered
Hearing Aids for Members under age 18 Limited to one per ear every 3 years (as determined by Your Annual Benefit Period)	70%	50% of the Maximum Allowable Charge
Therapy Services: Physical, speech, occupational, and spinal manipulation therapy limited to 30 visits per therapy type per Annual Benefit Period; Cardiac and pulmonary rehab therapy limited to 36 visits per Annual Benefit Period	70%	50% of the Maximum Allowable Charge
Home Health Care Services, including home infusion therapy Prior Authorization is required for skilled nurse visits in the home. Physical, speech or occupational therapy provided in the home do not require Prior Authorization. Limited to 100 visits per Annual Benefit Period	70%	50% of the Maximum Allowable Charge
PhysicianNow consultations via telephone, tablet or computer See the "Health and Wellness" section of this EOC for more information.	70%	Not Covered
Coinsurance percentages will be applied to the lesser of the negotiated fee or other basis for Our reimbursement of Covered Services.		

3. In the **Schedule of Benefits** the section **OUT-OF-POCKET MAXIMUM**, has been modified and reads as follows:

OUT-OF-POCKET MAXIMUM:

	Network	**Out-of-Network**:
Individual	$5,250	$15,750
2-Person	$10,500	$31,500
Family	$10,500	$31,500

Psychiatric Care Maximums	**Network Provider**	**Out-of-Network Provider**
Inpatient Benefits payable per Benefit Period	70%	50% of the Maximum Allowable Charge
Outpatient Benefits payable per Benefit Period	70%	50% of the Maximum Allowable Charge
Benefits will not be provided for more than two Inpatient stays for Substance Abuse Treatment.		

4. In the **Schedule of Benefits** the **Schedule of Pharmacy Prescription Drug Coinsurance** has been modified and reads as follows:

Schedule of Pharmacy Prescription Drug Coinsurance

	One month supply (Up to 30 days)	Two months' supply (31 to 60 days)	Three months' supply (61 to 90 days)
Generic Drug/Preferred Brand Drug/Non-Preferred Brand Drug			
RX04 Retail Network	70%/70%/70% after Deductible	N/A	N/A
Home Delivery Network	70%/70%/70% after Deductible	70%/70%/70% after Deductible	70%/70%/70% after Deductible
Plus90 Network	70%/70%/70% after Deductible	70%/70%/70% after Deductible	70%/70%/70% after Deductible
Compound Drugs	70%/70%/70% after Deductible	70%/70%/70% after Deductible	70%/70%/70% after Deductible
Out-of-Network	50% after Deductible		

5. In the **Schedule of Benefits** the **Self-administered Specialty Drugs** schedule has been modified and reads as follows:

Self-administered Specialty Drugs **Limited up to a 30-day supply per Prescription**	
Specialty Pharmacy Network	70% after Plan Deductible
Other Network Pharmacies	Not Covered
Out-of-Network	Not Covered

Prescriptions are filled in 30-day supplies at all network retail pharmacies; 90-day supplies are available through the Home Delivery Network and the Plus90 Network. See bcbst.com to locate network pharmacies and to learn more about the Home Delivery Network.

At the Network Pharmacy, You will pay the lesser of Your Coinsurance, or the Pharmacy's charge.

Your Coinsurance varies based on the days' supply dispensed as shown above.

Some products may be subject to additional Quantity Limitations and Step Therapy as adopted by Us.

If You or the prescribing physician choose a Preferred or Non-Preferred Brand Drug when a Generic Drug equivalent is available, You will be financially responsible for the amount by which the cost of the Preferred or Non-Preferred Brand Drug exceeds the Generic Drug cost plus the required Generic Drug Copayment.

If You have a Prescription filled at an Out-of-Network Pharmacy, You must pay all expenses and file a claim for reimbursement with the administrator. You will be reimbursed based on the Maximum Allowable Charge, less any applicable Deductible and/or Coinsurance amount.

6. In the **Schedule of Benefits**, the section **Organ Transplants Services** has been modified and reads as follows:

Organ Transplant Services			
Organ Transplant Services, all transplants except kidney	**In-Transplant Network benefits**: 70% after Network Deductible, Network Out-of-Pocket Maximum applies.	**Network Providers not in Our Transplant Network:** 70% of Transplant Maximum Allowable Charge (TMAC) after Network Deductible, Network Out-of-Pocket Maximum applies, amounts over TMAC do not apply to the Out-of-Pocket Maximum and are not Covered.	**Out-of-Network Providers**: 50% of Transplant Maximum Allowable Charge (TMAC), after Out-of-Network Deductible, Out-of-Network Out-of-Pocket Maximum applies, amounts over TMAC do not apply to the Out-of-Pocket and are not Covered.
Organ Transplant Services, kidney transplants	**Network Providers:** 70% after Network Deductible; Network Out-of-Pocket Maximum applies.		**Out-of-Network Providers**: 50% of Maximum Allowable Charge (MAC), after Out-of-Network Deductible, Out-of-Network Out-of-Pocket Maximum applies, amounts over MAC do not apply to the Out-of-Pocket and are not Covered.
Network Providers not in Our Transplant Network include Network Providers in Tennessee and BlueCard PPO Providers outside Tennessee.			

7. Under the section **SPECIAL PROVISIONS**, item number 1 has been modified and now reads as follows:

1. Benefits will be payable at 70% for covered expenses rendered in connection with correction of nerve interference and its effects by manual or mechanical means where the interference results from or is related to distortion, misalignment, or subluxation of or in the vertebral column (spinal manipulation therapy). Services limited to 30 visits per Annual Benefit Period. The 70% Coinsurance will not apply to any Out-of-Pocket maximums.

IF YOU HAVE ANY QUESTIONS ABOUT THIS SMM OR ANY OTHER MATTER RELATED TO YOUR MEMBERSHIP IN THE PLAN, PLEASE WRITE OR CALL US AT:

CUSTOMER SERVICE DEPARTMENT
BLUECROSS BLUESHIELD OF TENNESSEE, INC.,
ADMINISTRATOR
1 CAMERON HILL CIRCLE
CHATTANOOGA, TENNESSEE 37402
(800) 565-9140

BlueCross BlueShield of Tennessee®

1 Cameron Hill Circle
Chattanooga, Tennessee
37402

www.bcbst.com

BENEFIT QUESTIONS?

Call the Customer Service Number on the membership I.D. Card

SELF-FUNDED EOC

Printed 2017