of Tennessee

United Cleanup Oak Ridge LLC (UCOR)

Effective Date: 03/03/2025

Network: S

Benefit Summary

ORRCC - Pre-65 Retirees - Plan E - Opt. 6

Benefit Plan Features:	Your Cost In-Network	Your Cost Out-of-Network [1]
Annual Deductible		
Individual/Family	$400 / $800	$1,00 / $2,000
Annual Out-of-Pocket Maximum (includes copay, coinsurance and deductibles)		
Individual/Family	$5,100 / $10,200	$13,200 / $26,400
4th Quarter Carry-over	Excluded	
Covered Services		
Preventive Care Services (see page 4 for a list)	Covered at 100%	40% after deductible
Practitioner Office Services		
Primary Care Office Visits [20]	$30 copay	40% after deductible
Specialist Office Visits	$45 copay	40% after deductible
Office Surgery [3, 4, 6, 20]	$30 or $45 copay	40% after deductible
Routine Diagnostic Lab, X-Ray & Injections	$50 copay	40% after deductible
Advanced Radiological Imaging [2, 4, 7]	20% after deductible	40% after deductible
Provider-Administered Specialty Drugs [3, 4, 23]	20% after deductible / Up to $400	Not Covered
Teladoc Health® Virtual Care [17]	$30 copay	Not Covered
Services Received at a Facility (includes professional and facility charges)		
Inpatient Services [2, 4]	$100 copay	$300 copay / 40% after deductible
Outpatient Surgery [3, 4, 6]	$100 copay	40% after deductible
Routine Diagnostic Services - Outpatient	$50 copay	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
Urgent Care Center Services	$75 copay	40% after deductible
Emergency Care Services [9]	$200 copay	$200 copay
Emergency Care Advanced Radiological Imaging [7]	No additional copay	No additional copay
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) (1 per ear every 3 years)	20% after deductible	40% after deductible
Behavioral Health Services		
Inpatient: Unlimited days per annual benefit period [2, 4]	$100 copay	$300 copay / 40% after deductible
Outpatient: Unlimited visits per annual benefit period [5]	$30 copay	40% after deductible
Therapeutic Services [10] **(limits apply; see footnote)**	$45 copay	40% after deductible
Skilled Nursing & Rehabilitation Facility Services [2, 4]		
Limited to 120 days combined per annual benefit period	$100 copay	$300 copay / 40% after deductible
Home Health Care Services [3, 4, 10]	20% after deductible	40% after deductible
Hospice Services		
Inpatient [2, 4]	$100 copay	$300 copay / 40% after deductible
Outpatient	20% after deductible	40% after deductible

Ambulance Services [3, 4]	$200 copay	$200 copay
Prescription Drugs [3]		
Prescription Contraceptives [16]	Covered at 100%	20% after deductible
Retail RX03 Network up to 30 day supply [13]		
Preferred Generic	20% after deductible	20% after deductible
Non-Preferred Generic	20% after deductible	20% after deductible
Preferred Brand [15]	20% after deductible	20% after deductible
Non-Preferred Brand [15]	20% after deductible	20% after deductible
Plus90 or Home Delivery Network up to 90 day supply [14]		
Preferred Generic	20% after deductible	20% after deductible
Non-Preferred Generic	20% after deductible	20% after deductible
Preferred Brand [15]	20% after deductible	20% after deductible
Non-Preferred Brand [15]	20% after deductible	20% after deductible
Preventive Drugs [21]		
Generic - 30 day supply	$10 copay	Not Covered
Preferred Brand - 30 day supply	$35 copay	Not Covered
Non-Preferred Brand - 30 day supply	$60 copay	Not Covered
Preventive Drugs Mail Order [21]		
Generic - 30 day supply	$10 copay	Not Covered
Generic - 60 day supply	$20 copay	Not Covered
Generic - 90 day supply	$30 copay	Not Covered
Preferred - 30 day supply	$35 copay	Not Covered
Preferred - 60 day supply	$70 copay	Not Covered
Preferred - 90 day supply	$105 copay	Not Covered
Non-Preferred - 30 day supply	$60 copay	Not Covered
Non-Preferred - 60 day supply	$120 copay	Not Covered
Non-Preferred - 90 day supply	$180 copay	Not Covered
Self-Administered Specialty Drugs [3, 11, 12]		
Preferred Specialty Drugs	20% after deductible / Up to $400	Not Covered
Non-Preferred Specialty Drugs	20% after deductible / Up to $400	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 physicians services as well as chemotherapy, infusions, injections, radiation therapy and renal dialysis.
9. Copay, if applicable, waived if admitted to hospital.
10. Physical, speech, acupuncture, spinal manipulative and occupational therapies are limited to 60 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.
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.
17. Use Teladoc Health's virtual care platform to access doctors or professionals for 24/7 urgent care, mental health care, dermatology services, and more. Visit www.bcbst.com/teladoc or call 1-800-TELADOC (1-800-835-2362) to register.
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.
21. This plan provides copays for preventive care medications instead of having to meet your plan's deductible for certain prescription drugs. This list contains some of the most commonly prescribed preventive care drugs and is not all-inclusive. Visit www.bcbst.com/rx for the BlueCross Preventive Drug List.
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

• 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

• 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

BlueCross BlueShield of Tennessee (BlueCross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex[1]. BlueCross does not exclude people or treat them less favorably because of race, color, national origin, age, disability or sex.

BlueCross:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as: (1) qualified sign language interpreters and (2) written information in other formats, such as large print, audio and accessible electronic formats.
- Provides free language assistance services to people whose primary language is not English, such as: (1) qualified interpreters and (2) information written in other languages.

If you need these reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711).

If you believe that BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance ("Nondiscrimination Grievance"). For help with preparing and submitting your Nondiscrimination Grievance, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711). They can provide you with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address your Nondiscrimination Grievance to: Nondiscrimination Grievance; c/o Manager, Operations, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; (423) 591-9208 (fax); Nondiscrimination_OfficeGM@bcbst.com (email).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–368–1019, 800–537–7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

You can contact BlueCross's Nondiscrimination Coordinator at 423-535-1010 (TTY: 1-800-848-0298 or 711); Nondiscrimination_CoordinatorGM@bcbst.com (email); or Corporate Compliance, 1 Cameron Hill Circle, 1.4, Chattanooga, TN 37402.

This notice is available at BlueCross's website: bcbst.com.

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

BlueCross BlueShield of Tennessee is a Qualified Health Plan Issuer in the Health Insurance Marketplace.

[1] Consistent with the scope of sex discrimination described at 45 CFR 92.101(a)(2))

ATTENTION: If you speak English, free language assistance services and appropriate auxiliary aids and services are available to you. Please call the Member Service number on the back of your Member ID card or 1-800-565-9140 (TTY: 1-800-848-0298).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma, así como ayudas y servicios auxiliares adecuados. Llame al número de Servicio de atención a miembros que figura en el reverso de su tarjeta de identificación de miembro o al 1-800-565-9140 (TTY: 1-800-848-0298).

انتباه: إذا كنت تتحدث العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية والخدمات والأدوات المساعدة المناسبة. يرجي الاتصال برقم خدمة الأعضاء الموجود على ظهر بطاقة هوية العضو الخاص بك أو بالرقم 1-800-565-9140 (الهاتف النصي: 1-800-848-0298)

注意：如果您說中文，我們提供免費的語言協助服務，以及適當的輔助協助和服務。請撥打會員 ID 卡背面的會員服務部號碼或 1-800-565-9140（聽障專線 (TTY)：1-800-848-0298）。

LƯU Ý: Nếu quý vị nói tiếng Việt, quý vị sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí và các dịch vụ và công cụ hỗ trợ phù hợp. Vui lòng gọi đến số của bộ phận Dịch vụ Hội viên ở mặt sau Thẻ ID Thành viên của quý vị hoặc số 1-800-565-9140 (TTY: 1-800-848-0298).

주의: [한국어]를 사용하시는 경우, 무료 언어 지원 서비스 및 적절한 보조 기구와 서비스가 제공됩니다. 가입자 ID 카드 뒷면의 가입자 서비스 전화번호 또는 1-800-565-9140(TTY: 1-800-848-0298)번으로 전화하시기 바랍니다.

ATTENTION : Si vous parlez français, des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés sont à votre disposition. Veuillez appeler le numéro du Service adhérents indiqué au dos de votre carte d'assuré adhérent ou le 1-800-565-9140 (TTY/ATS : 1-800-848-0298).

ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາ ພາສາລາວ, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການທີ່ເໝາະສົມໃຫ້ທ່ານ. ກະລຸນາໂທຫາເບີຂອງຝ່າຍບໍລິການສະມາຊິກທີ່ມີຢູ່ດ້ານຫຼັງບັດ ID ສະມາຊິກຂອງທ່ານ ຫຼື 1-800-565-9140 (TTY: 1-800-848-0298).

ማስገንዘቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ረዳት መርጃዎች እና አገልግሎቶች ለእርስዎ ይገኛሉ። በአባልነት መታወቂያዎ ጀርባ ላይ በሚገኘው የአባላት አገልግሎት ቁጥር ወይም በ 1-800-565-9140 (TTY: 1-800-848-0298) ይደውሉ።

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste und geeignete Hilfsmittel und Dienstleistungen zur Verfügung. Bitte rufen Sie die Nummer des Mitgliederdienstes auf der Rückseite Ihrer Mitglieds-ID-Karte oder 1-800-565-9140 (TTY: 1-800-848-0298) an.

ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારા માટે નિ:શુલ્ક ભાષા સહાય સેવાઓ અને યોગ્ય સહાયક સાધનો અને સેવાઓ ઉપલબ્ધ છે. કૃપા કરીને તમારા સભ્ય ID કાર્ડની પાછળના સભ્ય સર્વિસ નંબર ઉપર અથવા 1-800-565-9140 (TTY: 1-800-848-0298) પર કૉલ કરો.

お知らせ：日本語をお話しになる場合は、無料の支援サービスと適切な補助器具・サービスがご利用いただけます。会員IDカードの裏面に記載の会員サービス番号あるいは1-800-565-9140 (TTY: 1-800-848-0298)まで、お電話にてご連絡ください。

PANSININ: Kung kayo ay nagsasalita ng Tagalog, magagamit para sa inyo ang libreng mga serbisyong tulong sa wika at kaukulang mga karagdagang tulong at mga serbisyo. Mangyaring tawagan ang numero ng Serbisyo sa Miyembro na nasa likod ng inyong Kard ng ID ng Miyembro o sa 1-800-565-9140 (TTY: 1-800-848-0298).

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएँ और उपयुक्त सहायक साधन और सेवाएँ उपलब्ध हैं। कृपया अपने सदस्य ID कार्ड के पीछे दिए गए सदस्य सेवा नंबर या 1-800-565-9140 (TTY: 1-800-848-0298) पर कॉल करें।

ВНИМАНИЕ! Если Вы говорите по-русски, Вам будут предоставлены услуги языковой поддержки и соответствующие вспомогательные средства и сервисы на бесплатной основе. Позвоните в отдел обслуживания участников по номеру, указанному на обратной стороне Вашей идентификационной карты участника, или по номеру 1-800-565-9140 (TTY: 1-800-848-0298).

توجه: اگر به زبان فارسی صحبت می کنید، خدمات کمک زبانی رایگان و مساعدت ها و خدمات کمکی مناسب در دسترس شما هستند. درصورتیکه عضو هستید، با شماره خدمات اعضا در پشت کارت عضویت خود یا 1-800-565-9140 (TTY: 1-800-848-0298) تماس بگیرید.

ATANSYON: Si w pale Kreyòl Ayisyen, genyen sèvis asistans gratis pou lang ansanm ak èd pou sèvis oksilyè apwopriye k ap disponib pou ou. Tanpri rele nimewo Sèvis Manm ki sou do kat ID Manm ou an oswa 1-800-565-9140 (TTY: 1-800-848-0298).

UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej oraz rozwiązań i usług pomocniczych. Prosimy zadzwonić pod numer działu obsługi ubezpieczonych podany na odwrocie karty identyfikacyjnej członka lub numer 1-800-565-9140 (TTY: 1-800-848-0298).

ATENÇÃO: Se você fala Português, serviços gratuitos de assistência linguística e recursos e serviços auxiliares apropriados estão disponíveis para você. Ligue para o número de telefone do serviço de Atendimento ao Membro informado no verso de seu cartão de identificação de membro ou para 1-800-565-9140 (TTY: 1-800-848-0298).

ATTENZIONE: se parla italiano, sono disponibili per Lei servizi gratuiti di assistenza linguistica nonché aiuti e servizi ausiliari adeguati. Chiami il numero del Servizio per i membri riportato sul retro della Sua scheda identificativa del membro oppure il numero 1-800-565-9140 (TTY: 1-800-848-0298).

BAA'áKOHWIINIDZIN: Diné bizaad bee yáníłti'go, t'áá jiik'eh saad bee áka'aná'awo' bee áka'anída'awo'í dóó t'áadoole'é binahjį' bee adahodooníłígíí diné bich'į' anídahazt'i'í bee bika'aanída'awo'í ná dahóló. T'áá shóódí Bił Ha'dít'éhí Bika'aná'awo' Bił Ha'dít'éhí ID naaltsoos nitł'izí bine'dę́ę́' binámboo bee hodíilnih doodago 1-800-565-9140 (TTY: 1-800-848-0298).

WICHDICH: Wann du Deitsch schwetzscht un brauchscht Hilf fer communicat-e kenne mer dich helfe unni as es dich ennich eppes koschde zellt. Mir kenne differnti Sadde Schprooch-Hilf beigriege aa fer nix. Ruf der Member Service Number uff die hinnerscht Seit vun dei Member ID Card uff odder 1-800-565-9140 (TTY: 1-800-848-0298).

FAASILASILAGA: Afai e te tautala i le faa-Samoa, o loo avanoa mo oe auaunaga fesoasoani mo gagana e aunoa ma se totogi faapea ma fesoasoani fa'aopo'opo ma auaunaga talafeagai. Faamolemole vala'au le numera o le Member Service (Auaunaga mo Tagata Auai) o lo'o i tua o lau pepa ID o le Member (Tagata Auai) po o le 1-800-565-9140 (TTY: 1-800-848-0298).

GAKIULA: Gare iga go kapetal Faluwasch, ye toore paliuwal yamem bwe tepangug rel gamatefal lane kapetal Faluwasch. Fale peshem kol yegili nampal Member Service ila yelog liugul tagurul Member ID kard la yam gare 1-800-565-9140 (TTY: 1-800-848-0298).

ATENSION: Guaha setbisio siha para hågu yanggen fifino' CHamoru hao, dibåtde na setbision inayudon fumino' CHamoru yan propriu na inasisten tråstes yan setbisio siha. Put fabot ågang i numiron Setbision Membro gi santatten i kattå-mu Member ID pat 1-800-565-9140 (TTY: 1-800-848-0298).