

Group: Blue Line Solutions, LLC

Group ID: 133433 - 1

Plan Information (HSA Qualified)
Plan Name: Bronze 74S (\$6200/\$7400/60%)

Network: Blue Network S

Effective Date: 12/01/2025

Benefit Plan Features
Cost In-Network
Cost Out-of-Network¹
Annual Deductible

Individual / Family	\$6,200 / \$12,400	\$12,400 / \$24,800
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Annual Out-of-Pocket Maximum (includes copays, coinsurance and deductibles)

Individual / Family	\$7,400 / \$14,800	\$22,200 / \$44,400
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Covered Services

Preventive Care Services ¹³ (see below for a list)	Covered at 100%	50% after Deductible
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Practitioner Office Services

Primary Care Office Visits	40% after Deductible	50% after Deductible
Specialist Office Visits	40% after Deductible	50% after Deductible
Office Surgery ^{4, 5, 6}	40% after Deductible	50% after Deductible
Routine Diagnostic Lab, X-Ray & Injections	40% after Deductible	50% after Deductible
Advanced Radiological Imaging ^{3, 5, 7}	40% after Deductible	50% after Deductible
Teladoc Health® Virtual Care	40% after Deductible	Not Covered

Services Rendered at a Facility (includes professional and facility charges)

Inpatient Services ^{3, 5}	40% after Deductible	50% after Deductible
Outpatient Surgery ^{4, 5, 6}	40% after Deductible	50% after Deductible
Routine Diagnostic Services – Outpatient	40% after Deductible	50% after Deductible
Advanced Radiological Imaging – Outpatient ^{3, 5, 7}	40% after Deductible	50% after Deductible
Other Outpatient Services ⁸	40% after Deductible	50% after Deductible
Urgent Care Center Services	40% after Deductible	50% after Deductible
Emergency Care Services ¹⁰	\$500 + Ded/Coins	\$500 + Ded/Coins
Emergency Care Advanced Radiological Imaging ⁷	40% after Deductible	40% after Deductible

Skilled Nursing & Rehabilitation Facility Services ^{3, 5}

Limited to 60 days combined per annual benefit period	40% after Deductible	50% after Deductible
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Medical Equipment ^{4, 5}

Durable Medical Equipment	40% after Deductible	50% after Deductible
Prosthetics & Orthotics	40% after Deductible	50% after Deductible
Hearing Aids ²²	40% after Deductible	50% after Deductible

Benefit Plan Features (cont.)	Cost In-Network	Cost Out-of-Network ¹
Behavioral Health Services		
Inpatient: Unlimited days per annual benefit period ^{3, 5}	40% after Deductible	50% after Deductible
Outpatient: Unlimited days per annual benefit period ¹⁴	40% after Deductible	50% after Deductible
Therapy Services		
Rehabilitative ^{4, 5, 9} & Habilitative ^{4, 5, 21} Limits apply; see footnotes	40% after Deductible	50% after Deductible
Home Health Care Services ^{4, 5, 9, 21}		
Home Health Care Services	40% after Deductible	50% after Deductible
Hospice Services ^{5, 23}		
Hospice Services	40% after Deductible	50% after Deductible
Ambulance Services ⁴		
Ambulance Services	40% after Deductible	40% after Deductible
Prescription Drugs ^{4, 11, 12, 16, 18, 20}		
Prescription Contraceptives ¹⁶	Covered at 100%	50% after Deductible
Retail Network, Plus90, or Home Delivery Network ¹⁵		
Generic	\$10 Copay after Deductible	50% after Deductible
Preferred	\$35 Copay after Deductible	50% after Deductible
Non-Preferred	\$50 Copay after Deductible	50% after Deductible
Self-Administered Specialty Drugs ^{17, 24}		
Preferred Specialty Pharmacy Network	\$100 Copay after Deductible	Not Covered
Provider-Administered Specialty Drugs ^{4, 17}		
Preferred Specialty Pharmacy Network	\$100 Copay after Deductible	Not Covered

Notes

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. The lower copay applies to Family Medicine, General Practice, General Internal Medicine, OB/GYN, Pediatrics, and Behavioral Health services. The copay for Physician Assistants or Nurse Practitioners may be based on the provider type of the billing provider.
3. Prior authorization is required.
4. Certain procedures, services, medication and equipment may require prior authorization.
5. 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, benefits will be reduced to 50%. If services are not medically necessary, no benefits will be provided.
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. Physical, speech, acupuncture, spinal manipulation and occupational therapies are limited to 20 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.
10. Copay, if applicable, waived if admitted to hospital.
11. Visit www.bcbst.com/rx for the Essential Formulary which includes specialty drugs.
12. Copay, if applicable, applied per prescription, up to a 30 day supply.
13. Services include annual physical, childhood immunizations, recommended adult immunizations and vision and hearing screenings performed by the physician during the preventive health exam.
14. 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.
15. 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.
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 on the drug formulary with an "ACA" indicator. Visit www.bcbst.com/rx for the Essential Formulary.
17. You have a distinct network for self-administered specialty drugs and provider-administered specialty drugs. To receive benefits, you must use a Preferred Specialty Pharmacy Network provider. Visit www.bcbst.com/rx for a list of providers in the Preferred Specialty Pharmacy Network. Self-administered specialty drugs are limited to a 30 day supply.
18. If applicable, the 90-day supply copay is reduced to 2.5x the 30-day supply copay. Visit bcbst.com to find a list of pharmacies in the Plus90 Network.
19. If applicable, 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 Essential Plus Formulary.
20. 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.
21. Therapy Services - Habilitative: Physical, speech and occupational therapies are limited to 20 visits per therapy type per annual benefit period.
22. Limited to 1 per ear every 3 years.
23. Inpatient Hospice requires prior authorization.
24. If you receive copay assistance that discounts the cost of certain specialty drugs, the plan may reduce the benefits it provides in proportion to the amount of the copay assistance. Additionally, the plan may exclude from accumulation toward any deductible or out-of-pocket maximum the value of any copay assistance applied to any copayment, deductible and/or coinsurance that the plan would require you to pay if you did not receive the copay assistance.

Limitations and Exclusions: These pages summarize the benefits of your health care plan. Your Evidence of Coverage (EOC) defines 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.

Group: Blue Line Solutions, LLC**Group ID:** 133433 - 1**Plan Information (HSA Qualified)****Plan Name:** Bronze 74S (\$6200/\$7400/60%)**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 (age 45 and older for women; age 35 and older for men), high blood pressure, obesity, diabetes and depression (age 12 and older)
- Screening for lung cancer for adults (age 50 - 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 primary care setting for alcohol misuse and tobacco use; alcohol misuse and tobacco cessation counseling limited to 8 visits per type per annual benefit period
- Dietary counseling for adults with hyperlipidemia, hypertension, type 2 diabetes, obesity, coronary artery disease and/or 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 and supplies, including lactation support services and counseling by a trained provider and one breast pump per pregnancy
- Counseling women at high risk of breast cancer for chemoprevention, including risks and benefits
- Mammography screening (age 40 and older) and genetic counseling and, if indicated after counseling, BRCA testing for BRCA breast cancer gene
- Osteoporosis screening (age 60 and 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 (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

Pediatric Dental ²

Benefit Plan Features	Your Cost In-Network	Your Cost Out-of-Network ¹
Coverage A		
Diagnostic and Preventive Services		
Exams	No Member Cost Share	No Member Cost Share
Cleanings		
X-Rays		
Coverage B		
Basic Restorative Services		
Basic Endodontics and Periodontics	20%	20%
Oral Surgery		
Coverage C		
Major Restorative and Prosthodontics		
Major Endodontics and Periodontics	50%	50%
Implants		
Coverage D (Requires Prior Authorization)		
Medically Necessary Orthodontia	40% after Deductible	50% after Deductible

Pediatric Vision ²

Benefit Plan Features	Your Cost In-Network	Your Cost Out-of-Network ¹
Exams ³		
Comprehensive Eye Exam	No Member Cost Share	40%
Contact Lens Fitting and Follow-Up (limited to two)		
Frames ⁴		
Designated available frame at provider location	No Member Cost Share	40%
Standard Lenses (Glass or Plastic) ^{3, 4}		
Single		
Bifocal		
Trifocal	No Member Cost Share	40%
Lenticular		
Standard Progressive		
Lens Options ^{3, 4}		
Standard Polycarbonate		
UV Treatment		
Tint	No Member Cost Share	40%
Standard Plastic Scratch Coating		
Photochromic / Transitions Plastic		
Contacts (includes materials only) ^{3, 4}		
Extended Wear / Extended Wear Disposables	No Member Cost Share	40%
Daily Wear / Disposables		

Notes

1. Out-of-network benefit payment based on maximum allowable charge. You are responsible for paying any amount exceeding the maximum allowable charge.
2. Coverage for members under age 19 only.
3. Vision exams, eyeglass frames and lenses, and contact lenses are covered once every annual benefit period. Prescription sunglasses will be handled as any other lens.
4. Certain restrictions apply.

Limitations and Exclusions: These pages summarize the benefits of your health care plan. Your Evidence of Coverage (EOC) defines 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.

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 sex¹. 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@bcbsb.com (email); or Corporate Compliance, 1 Cameron Hill Circle, 1.4, Chattanooga, TN 37402.

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

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

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Si usted es miembro, llame al número de Servicio de atención a miembros que figura al reverso de su tarjeta de identificación de Miembro o al 1-800-565-9140 (TTY: 1-800-848-0298).

ملحوظة: إذا كنت تتحدث انكليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالجان. إذا كنت عضواً، فلتصل برقم خدمة الأعضاء الموجود على ظهر بطاقة هوية العضو أو بالرقم 1-800-565-9140 (الهاتف النسي: 1-800-848-0298).

注意：如果您使用繁體中文，您可以免費獲得語音援助服務。若您是會員，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）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Nếu quý vị là hội viên, hãy gọi đến số Dịch vụ Hội viên ở mặt sau thẻ ID Hội viên của quý vị hoặc 1-800-565-9140 (TTY: 1-800-848-0298).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 가입자의 경우, 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 d'aide linguistique vous sont proposés gratuitement. Si vous êtes adhérent, appelez le numéro du Service adhérents indiqué au dos de votre carte d'assuré adhérent ou appelez le 1-800-565-9140 (TTY/ATS : 1-800-848-0298).

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ግብይቱ፣ የሚሰጡት ድጋፍ አገልግሎት ከሆነ የትርጉም ለርሳት ድርጅቶች፣ በአገልግሎት ተደርጎታል፡ ለሌላ ከሆነ፡ በሌላነት መታወቂያ ጀርባ ላይ በሚገኘው የሌላነት አገልግሎት ቁጥር መደድ በ 1-800-565-9140 (መስማት ለተሰማው፡ TTY: 1-800-848-0298) ይደረጋል፡

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Falls Sie ein Mitglied sind, rufen Sie die Nummer des Mitgliederdienstes auf der Rückseite Ihrer Mitglieds-ID-Karte oder 1-800-565-9140 (TTY: 1-800-848-0298) an.

સુખના જો તમે મુશ્કેલી યોગના લો, તો નિઃશ્વસ ભાવ સદા સેવાઓ તમારા માટે ઉપલબ્ધ છે. જો તમે સમજો છો, તો તમારા સમજ આવી પહોંચી જઈને પાછળના સમજ સર્વોચ્ચ નંબર ઉપર અથવા 1-800-565-9140 (TTY: 1-800-848-0298) પર કોલ કરો.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。会員のお客様は、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。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Kung ikaw ay isang miyembro, tawagan ang numero ng Serbisyo sa Miyembro na nasa likod ng iyong 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 सूचना में भाषा सहायता सेवाएं उपलब्ध हैं। अगर आप सदस्य हैं तो अपने सदस्य आईडी कार्ड के पीछे दिए गए नंबर या 1-800-565-9140 (TTY: 1-800-848-0298) पर सदस्य सेवा नंबर पर फोन करें।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Если Вы являетесь участником, 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 گفتگو می کنید، سهیدیت زبانی بصورت رایگان برای شما فراهم می باشد. در صورتیکه عضو هستید، یا شماره خدمات اعضا در پشت کارت شناسایی عضو خود یا 1-800-565-9140 (TTY: 1-800-848-0298) تماس بگیرید.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis ed pou lang ki disponib gratis pou ou. Si ou se yon manm, rele nimewo Sèvis Manm ki sou do kat ID Manm ou an oswa 1-800-565-9140 (TTY: 1-800-848-0298).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Członkowie mogą dzwonić pod numer działu Member Service podany na odwrocie karty identyfikacyjnej członka lub numer 1-800-565-9140 (TTY: 1-800-848-0298).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Caso seja membro, ligue para o 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: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Se è un membro, 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).

Dii baa akó ninizin: Dii saad bee yáñt'ígo Díné Bizaad, saad bee áká'anída'áwo'déé, t'áá Jík'eh, éí na' hólq. Naaltsoos bee na' ha'dit'ígoo, Naaltsoos Bə Hada'dit'ehgii ninaaltsoos nit'ízi bee néehoozínigii bine'déé' Naaltsoos Bə Hada'dit'ehgii Bee Aka'anída'áwo' bíbéeé bee hane'í biká'ígii bee hodinih doodaag 1-800-565-9140 (Doo Adinits'apógoo q TTY: 1-800-848-0298) bee hodinih.

WICHTIG: Wann du Deutsch schwetzschst un witt en Translator, kenne mer eener griege fer dich unni as es dich ennich ebbes koschte zelt. Wann du en Member bischt, ruf der Member Service Number uff as uff die hinnerscht Seit vun der Member ID Card is odder ruf 1-800-565-9140 (TTY: 1-800-848-0298) uff.

FAAMATALAGA: Afai e te tautala i le Gagana Samoa, o lo'o avanaga mo oe auunaga fesoasoani i le gagana e leai se tofoti. Afai o oe o se sui, fa'amolemole vala'au le numera o le Member Service o lo'o i tua o lau pepa ID po'o le 1-800-565-9140 (TTY: 1-800-848-0298).

ATENSHUN: Gare iga gogal Kapasal Falawasch, ye fri ngalug yamem bwe tepangug rei iye kepat kaale. Nge gare iga gel gosa fasiul log bwe semal member, gosa kol yegili nampal Member Service woal pak rei Member ID kard la yamw gare kol yegili 1-800-565-9140 (TTY: 1-800-848-0298).

ATENSIÓN: Kumu un tungo fuminu' Chamoru, guaha dibatdi na setbision asistentun lengguahi para hãgu. Kumu membro hao, pot fabot agang i Setbision Membro na numeru gi santatin iyomu ID card Membro pa'i 1-800-565-9140 (TTY: 1-800-848-0298).

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