PARTNERS FOR HEALTH

State of Tennessee 2015
Member Handbook+
Limited PPO

of Tennessee

Important Notice

This member handbook explains many features of the Limited PPO health care option. It describes your benefits in general terms and is not intended to give all the details of every benefit, limitation or exclusion. The information contained in this handbook is accurate at the time of printing. However, the Insurance Committees may change the benefits at their discretion, in which case you will be given written notice of the change.

The Plan Document is the official legal publication that defines eligibility, enrollment, benefits and administrative rules of the state group insurance program. A copy is available for your review from your agency benefits coordinator or from the State of Tennessee Benefits Administration website at www.tn.gov/finance/ins/.

Benefits Administration does not support any practice that excludes participation in programs or denies the benefits of such programs on the basis of race, color, or national origin. If you have a complaint regarding discrimination, please call 1-866-576-0029 or 615-741-4517.

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Welcome

Thank you for choosing the Limited PPO option administered by BlueCross BlueShield of Tennessee. For more than 60 years, BlueCross BlueShield of Tennessee has been centered on the health and well being of Tennesseans. Today, more than 2 million people across the state turn to us for health plan coverage products and services. We are an independent, not-for-profit, locally governed health plan company. This means we live and work alongside our Tennessee customers and plan members. We also are part of the BlueCross BlueShield Association, a nationwide association of health care plans. Because of this, our plan members have access to the same quality health benefits while traveling or living out of state that they have while in Tennessee. As a result, our plan members also have the peace of mind that comes from having personal and financial health and security.

Plan Administration and Claims Administration

Benefits Administration, a division of the Department of Finance and Administration, is the plan administrator and BlueCross BlueShield of Tennessee is the claims administrator. This program is administered using the benefit structure established by the Insurance Committee that governs the plan. When claims are paid under this plan, they are paid from a fund consisting of your premiums and the employer's contributions (if applicable). BlueCross BlueShield of Tennessee is contracted by the state to process claims, establish and maintain adequate provider networks, and conduct utilization management reviews.

Claims paid in error for any reason will be recovered from the employee. Filing false or altered claim forms constitutes fraud and is subject to criminal prosecution. You may report possible fraud at any time by contacting Benefits Administration.

Eligibility and Enrollment Topics

All individuals who wish to cover dependents (spouse or children) must provide documentation verifying the eligibility of their dependents before the dependents will be enrolled in coverage. A list of appropriate documentation which may establish eligibility by dependent category is available from your agency benefits coordinator or the Benefits Administration website. Please refer to the Benefits Administration Eligibility and Enrollment Guide for detailed information on eligibility requirements.

Important Contact Information

Please call member service for information about specific health care claims. Our representatives are familiar with your specific coverage and are available to answer your questions. When contacting member service, you will be asked to verify your identity and give information from your identification card.

BlueCross BlueShield of Tennessee

Member Service: 1-800-558-6213, 7 a.m. – 4:15 p.m. (CST) M-F
Report Fraud: 1-800-496-9600
BlueCard Providers: 1-800-810-2583
Transplant Coordinator: 1-888-207-2421

Mailing address for claims:

BlueCross BlueShield of Tennessee
Claims Service Center
1 Cameron Hill Circle Ste 0002
Chattanooga, TN 37402-0002

Mailing address for pre-determination requests:

BlueCross BlueShield of Tennessee
Predeterminations/ODM, 2G
1 Cameron Hill Circle Ste 0014
Chattanooga, TN 37402-0014

Mailing address for unique and continuous care exception requests:

BlueCross BlueShield of Tennessee
State Unique Care/ Continuous Care
1 Cameron Hill Circle
Chattanooga, TN 37402

Behavioral Health and Substance Abuse/ ParTNers Employee Assistance Program

Magellan
1-855-437-3486

Pharmacy

CVS/caremark
1-877-522-8679

ParTNers for Health Wellness Program

Healthways
1-888-741-3390
www.partnersforhealthtn.gov

Website

In addition to our standard website at www.bcbst.com, members can access benefit and provider information with a web page specifically designed for state group insurance program participants. Point your web browser to www.bcbst.com/members/tn_state/ to search for providers and access other helpful information.

The website also features many helpful and easy-to-use online health tools, including the Find A Doctor tool and the most up-to-date version of the provider directory. Whether you use a printed directory, or the online version, be sure to search for and select doctors, hospitals and other providers in your specific Blue Network, which is "**Blue Network S**."

Members may also use BlueAccess, the secure area of bcbst.com, to view your information in a secure environment using member self-service with a user ID and password. With your BlueAccess ID and password you can:

- Verify benefits, including eligibility and coverage details
- Check medical claim status (excludes prescription drug claims)
- Look up prior authorization status
- View and print an online explanation of benefits (EOB)
- Update your coordination of benefits (COB) information if you have other insurance coverage
- Order replacement ID cards

Registering and using BlueAccess is quick and easy. In addition to its many self-service tools, BlueAccess also contains many important consumer health tools that let you compare costs for medical services, hospitals and surgeries.

LIMITED PPO – Benefits at a Glance

TABLE 1: Services in this table ARE NOT subject to a deductible, with the exception of pharmacy. Costs DO APPLY to the annual out-of-pocket maximums on TABLE 3. For further benefit details and plan limits, see sections on Covered Expenses and Excluded Services and Procedures.

	In-Network	Out-of-Network [1]
Preventive Care		
Office Visits • Well-baby, well-child visits as recommended by the Centers for Disease Control and Prevention (CDC) • Adult annual physical exam • Annual well-woman exam • Immunizations as recommended by CDC • Annual hearing and non-refractive vision screening • Screenings including colonoscopy, mammogram, and colorectal, Pap smears, labs, bone density scans, nutritional guidance, tobacco cessation counseling and other services as recommended by the US Preventive Services Task Force	No Charge	$50 copay
Outpatient Services		
Primary Care Office Visit • Family practice, general practice, internal medicine, OB/GYN and pediatrics • Nurse practitioners, physician assistants and nurse midwives (licensed healthcare facility only) working under the supervision of a primary care provider • Including surgery in office setting and initial maternity visit	$ 35 copay	$ 55 copay
Specialist Office Visit • Including surgery in office setting	$ 55 copay	$ 80 copay
Behavioral Health and Substance Abuse Treatment [2] (benefits managed by Magellan Health Services)	$ 35 copay	$ 55 copay
X-Ray, Lab and Diagnostics • Including reading, interpretation, and results (not including advanced x-rays, scans, and imaging)	100% covered after office copay if applicable	100% covered up to MAC after office copay if applicable
Allergy Injection	100% covered	100% up to MAC
Allergy Injection with Office Visit	$ 35 copay primary; $ 55 copay specialist	$ 55 copay primary; $ 80 copay specialist
Chiropractors	Visits 1-20: $ 35 copay Visits 21 and up: $ 55 copay	Visits 1-20: $ 55 copay Visits 21 and up: $ 80 copay
PHARMACY - Benefits managed by CVS/caremark - see your prescription card for information		
Deductible	$100 per member	
Out-of-Pocket Maximum	included with medical	none
30-Day Supply	$10 copay generic; $ 55 copay preferred brand; $ 105 copay non-preferred brand	copay plus amount exceeding MAC
90-Day Supply (90-day network pharmacy or mail-order)	$20 copay generic; $ 105 copay preferred brand; $ 205 copay non-preferred brand	copay plus amount exceeding MAC
90-Day Supply (certain maintenance medications from 90-day network pharmacy or mail order) [4]	$10 copay generic; $ 50 copay preferred brand; $ 200 copay non-preferred	copay plus amount exceeding MAC
Urgent Care		
Convenience Clinic or Urgent Care Facility	$ 40 copay	
Emergency Care		
Emergency Room Visit (waived if admitted) *	$ 165 copay	

* Services subject to coinsurance may be extra

LIMITED PPO–
Benefits at a Glance

TABLE 2: Services in this table ARE subject to a deductible and eligible expenses DO APPLY to the annual out-of-pocket maximum. For further benefit details and plan limits, see TABLE 3 (deductible and out-of-pocket maximum amounts) and sections on Covered Expenses and Excluded Services and Procedures.

	In-Network	**Out-of-Network** [1]
Hospital/Facility Services (includes professional and facility charges) • Inpatient care [3] • Outpatient surgery [3] • Inpatient behavioral health and substance abuse (benefits managed by Magellan Health Services) [2] [3]	30% coinsurance	50% coinsurance
Maternity • Global billing for labor and delivery and routine services beyond the initial office visit	30% coinsurance	50% coinsurance
Home Care [3] • Home health • Home infusion therapy	30% coinsurance	50% coinsurance
Rehabilitation and Therapy Services • Inpatient [3]; outpatient • Skilled nursing facility [3]	30% coinsurance	50% coinsurance
Ambulance • Air and ground	30% coinsurance	
Hospice Care [3] • Through an approved program	100% covered up to MAC (even if deductible has not been met)	
Equipment and Supplies [3] • Durable medical equipment and external prosthetics • Other supplies (i.e., ostomy, bandages, dressings)	30% coinsurance	50% coinsurance
Dental • Certain limited benefits (extraction of impacted wisdom teeth, excision of solid-based oral tumors, accidental injury, orthodontic treatment for facial hemiatrophy or congenital birth defect)	30% coinsurance oral surgeons	50% coinsurance oral surgeons
	30% coinsurance non-contracted providers (i.e., dentists, orthodontists)	
Advanced X-Ray, Scans and Imaging • Including MRI, MRA, MRS, CT, CTA, PET, and nuclear cardiac imaging studies [3]	30% coinsurance	50% coinsurance
• Reading and interpretation	100% covered	100% covered up to MAC
Out-of-Country Charges • Non-emergency and non-urgent care	N/A – no network	50% coinsurance

[1] Out-of-Network services cost more. An out-of-network provider may charge more than the "maximum allowable charge". The MAC is the most that the plan will pay for a service from an in-network provider. If you go to an out-of-network provider who charges more than the MAC, you will pay any applicable copay or coinsurance amount PLUS the difference between the MAC and the actual charge. For out-of-network emergency services and ambulance services, you will not be responsible for amounts exceeding the allowable (maximum amount eligible for payment) unless the claims administrator determines the situation was not an emergency or not medically necessary.

[2] The following behavioral health services are treated as "inpatient" for the purpose of determining member cost-sharing: residential treatment, partial hospitalization and intensive outpatient therapy. For certain procedures, such as applied behavioral analysis, electroconvulsive therapy, transcranial magnetic stimulation and psychological testing, prior authorization is required.

[3] Prior authorization required. When using out-of-network providers, benefits for medically necessary services will be reduced by half if prior authorization is required but not obtained, subject to the maximum allowable charge. If services are not medically necessary, no benefits will be provided. (For DME, PA only applies to more expensive items.)

[4] Applies to certain antihypertensives; oral diabetic medications, insulin and diabetic supplies (needles, test strips, lancets); statins.

TABLE 3: DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM AMOUNTS. Services detailed in TABLES 1 and 2 are subject to these out-of-pocket maximum amounts. Services detailed in TABLE 2 are subject to the deductible amounts. No single family member will be subject to a deductible or out-of-pocket maximum greater than the "employee only" amount. Once two or more family members (depending on premium level) have met the total deductible and/or out-of-pocket maximum, it will be met by all covered family members. Only eligible expenses will apply toward the deductible and out-of-pocket maximum. Charges for non-covered services and amounts exceeding the maximum allowable charge will not be counted.

	In-Network	Out-of-Network
Deductible		
Employee Only	$1,200	$2,300
Employee + Child(ren)	$1,800	$3,350
Employee + Spouse	$2,100	$3,900
Employee + Spouse + Child(ren)	$2,600	$4,950
Out-Of-Pocket Maximum		
Employee Only	$6,600	$12,700
Employee + Child(ren)	$13,200	$25,400
Employee + Spouse	$13,200	$25,400
Employee + Spouse + Child(ren)	$13,200	$25,400

Covered Medical Expenses

Services, treatment and expenses will be considered covered expenses if:

- They are not listed in the Excluded Services and Procedures section of this handbook or the Plan Document; and
- They are consistent with plan policies and guidelines; and
- They are determined to be medically necessary and/or clinically necessary by the claims administrator, or
- Coverage is required by applicable state or federal law

If you are unsure about whether a procedure, type of facility, equipment, or any other expense is covered, ask your physician to submit a pre-determination request form to the claims administrator describing the condition and planned treatment. Pre-determination requests may take up to three weeks to review.

If you have scheduled a visit for a preventive service (for example a colonoscopy), it is very important that you talk to your healthcare provider about the type of service you will have. You will not have a copayment for in-network preventive services. However, you will be charged for services scheduled for diagnostic purposes or billed as anything other than preventive care.

Charges for the following services and supplies are eligible covered expenses under the Limited PPO. Prescription drug claims for drugs obtained from a retail pharmacy or mail order are processed under pharmacy benefits.

1. Immunizations, including but not limited to, hepatitis B, tetanus, measles, mumps, rubella, shingles, pneumococcal, and influenza, unless the employer is mandated to pay for the immunization. Immunization schedules are based on the Centers for Disease Control and Prevention guidelines and are subject to change (www.cdc.gov/vaccines).
2. Well-child visits to physicians including checkups and immunizations, 12 visits combined through age 5. Annual checkups for ages 6-17 and immunizations as recommended by the Centers for Disease Control and Prevention (CDC), (www.cdc.gov/vaccines).
3. Adult annual physical exam – age 18 and over.
4. Physician-recommended preventive health care services for women, including:
   - Annual well woman exam
   - Screening for gestational diabetes
   - Human papillomavirus (HPV) testing

- Counseling for sexually transmitted infections (annually)
- Counseling and screening for human immune-deficiency virus (annually)
- Contraceptive methods and counseling (as prescribed)
- Breastfeeding support, supplies and counseling (in conjunction with each birth)
  - Hospital Grade Electric Breast Pumps are eligible for rental only; not to exceed 3 months, unless medically necessary.
- Screening and counseling for interpersonal and domestic violence (annually)

5. CBC with differential, urinalysis, glucose monitoring - age 40 and over or earlier based on doctor's recommendations and medical necessity.
6. Prostate screening annually for men who have been treated for prostate cancer with radiation, surgery, or chemotherapy and for men over the age of 45 who have enlarged prostates as determined by rectal examination. This annual testing is also covered for men of any age with prostate nodules or other irregularity noted upon rectal exam. The PSA test will be covered as the primary screening tool of men over age 50 and transrectal ultrasound will be covered in these individuals found to have elevated PSA levels.
7. Hearing impairment screening and testing for the purpose of determining appropriate treatment of hearing loss in children and adults. Hearing impairment or hearing loss is a reduction in the ability to perceive sound and may range from slight to complete deafness. The claims administrator has determined eligibility of many of the test/screenings to be specific to infants. Availability of benefits should be verified with the claims administrator prior to incurring charges for these services.
8. Visual impairment screening/exam for children and adults, when medically necessary as determined by the claims administrator in the treatment of an injury or disease, including, but not limited to: (a) screening to detect amblyopia, strabismus, and defects in visual acuity in children younger than age 5 years; (b) visual screenings conducted by objective, standardized testing; and (c) routine screenings among the elderly considered medically necessary for Snellen acuity testing and glaucoma screening. Refractive examinations to determine the need for glasses and/or contacts are not considered vision screenings.
9. Other preventive care services based on your doctor's recommendations, including but not limited to the items listed below. To learn more about evidence-based recommendations from the U.S. Preventive Services Task Force (USPSTF) and coverage for preventive services required by the Affordable Care Act, visit www.uspreventiveservicestaskforce.org/recommendations.htm.
   - Cholesterol screening.
   - Routine osteoporosis screening (bone density scans).
   - Routine women's health, including, but not limited to, the following services: (a) Chlamydia screening; and (b) Cervical cancer screening including lab charges and associated office visits for Pap smears (per plan year); and (c) Gonorrhea screening; and (d) Screening for iron deficiency anemia in asymptomatic pregnant women; and (e) Asymptomatic bacteriuria screening with urine culture for pregnant women.
   - Mammogram screenings.
   - Healthy diet counseling for medical conditions other than diabetes, limited to three visits per plan year.
   - Alcohol misuse counseling – screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women in primary care settings, limited to eight per plan year.
   - Tobacco use counseling – including tobacco cessation interventions for non-pregnant adults who use tobacco products and augmented, pregnancy-tailored counseling to those pregnant women who smoke, limited to twelve per plan year.
   - Depression screening for adolescents and adults.
   - Colorectal screenings. Screening for colorectal cancer (CRC) in adults using fecal occult blood testing, sigmoidoscopy, or colonoscopy.
   - Aspirin to prevent cardiovascular disease for members 45 and older. A prescription is required, and coverage is limited to over-the-counter, generic 81mg aspirin with a maximum quantity of up to 100 every 90 days.
10. Office visits to a physician or a specialist due to an injury or illness.
11. Hospital room and board and general nursing care and ancillary services for the type of care provided if pre-authorized.
12. Charges for medically necessary surgical procedures and administration of anesthesia.
13. Charges for diagnostic laboratory and X-ray services.
14. Medically necessary ground and air ambulance services to and from the nearest general hospital or specialty hospital which is equipped to furnish treatment.
15. Blood plasma or whole blood (including components and derivatives) unless donated or replaced by you or a family member.
16. An approved hospice program that is designed to provide the terminally ill patient with more dignified, comfortable, and less costly care during the six months before death.
17. Durable medical equipment (DME), consistent with a patient's diagnosis, recognized as therapeutically

effective and prescribed by a physician and not meant to serve as a comfort or convenience item. Benefits are provided for either rental or purchase of equipment however, the total amount paid for monthly rentals cannot exceed the fee schedule purchase amount.

18. Family planning and infertility services including history, physical examination, laboratory tests, advice, and medical supervision related to family planning, medically indicated genetic testing and counseling, sterilization procedures, infertility testing, and treatment for organic impotence. If fertility services are initiated (including, but not limited to, artificial insemination and in-vitro fertilization), benefits will cease.
19. Removal of impacted wisdom teeth, excision of solid-based oral tumors, and treatment of accidental injury (other than by eating or chewing) to sound natural teeth.
20. Continuous passive motion machine for knee replacement surgery or anterior cruciate ligament repair for 28 days after surgery.
21. The initial purchase of an artificial limb (prosthetic device) necessary due to an illness or injury and subsequent purchases due to physical growth for a covered dependent through age 18. One additional limb prosthesis past age 18 will be covered if additional surgery has altered the size or shape of the stump, or if a severe medical condition could result from improper fitting of the initial prosthesis. Replacement prosthetic due to normal wear and tear or physical development, with written approval.
22. Expenses for temporomandibular joint malfunctions (TMJ) including history, exams, and office visits; X-rays of the joint, diagnostic study casts; appliances (removable or fixed); physical medicine procedures such as surgery; and medications.
23. Rehabilitation therapies. Medically necessary preauthorized inpatient and/or outpatient services performed by a registered/licensed physical, occupational, or speech therapist for conditions resulting from an illness or injury, or when prescribed immediately following surgery related to the condition. Therapies include speech therapy by a licensed speech therapist to restore speech after a loss or impairment (excluding mental, psychoneurotic or personality disorders) provided there is continued medical progress and functional, physical, and occupational therapy to the extent such therapy is performed to regain use of the upper or lower extremities, or if the covered person is a child, as long as there is continued medical improvement. Outpatient benefits are limited to 90 days per plan year for speech, physical, and occupational therapies combined. Occupational therapy may include cognitive therapy but shall not include vocational therapy or vocational rehabilitation, nor educational or recreational therapy. If medically appropriate, the claims administrator and/or utilization review organization may exceed the established plan limitations on outpatient therapies for covered person who, because of their illness, injury, loss, or impairment, require additional speech, physical and/or occupational therapy.
24. Eligible expenses for treatment of Autism Spectrum Disorders as specified in TCA 56-7-2367.
25. The first contact lenses or glasses (excluding tinting and scratch resistant coating) purchased after cataract surgery.
26. Multiple pairs of rigid contact lenses that are determined to be medically necessary by the claims administrator and prescribed only for the treatment of diagnosed keratoconus. Intrastromal Corneal Ring Segments (ICRS) for vision correction are also covered with a diagnosis of keratoconus when certain medical appropriateness criteria are met.
27. Cosmetic surgery only when in connection with treatment of a congenital anomaly that severely impairs the function of a bodily organ or due to a traumatic injury or illness; or reconstructive breast surgery if needed following a covered mastectomy (but not a lumpectomy), as well as surgery to the non-diseased breast to establish symmetry.
28. Diabetes outpatient self-management training and educational services including medical nutrition counseling when prescribed by a physician and determined to be medically necessary with a diagnosis of diabetes, limited to six visits per plan year. Coverage for additional training and education is available when determined to be medically necessary by the claims administrator. Health coaching for diabetic members is available through the ParTNers for Health Wellness Program.
29. Certain organ and bone marrow transplant medical expenses and services (prior authorization required). Hotel and meal expenses will be paid up to $150 per diem. The transplant recipient and one other person (guardian, spouse, or other caregiver) are covered. The maximum combined benefit for travel and lodging is $15,000 per transplant.
30. Orthopedic items, when medically necessary as determined by the claims administrator. These items include, but are not limited to, splints, crutches, back braces, knee braces, surgical collars, lumbosacral supports, rehabilitation braces, fracture braces, childhood hip braces, braces for congenital defects, splints and mobilizers, corsets-back and special surgical, trusses, and rigid back or leg braces.
31. Foot orthotics, including therapeutic shoes, if an integral part of a leg brace, therapeutic shoes (depth or custom-molded) and inserts for covered persons with diabetes mellitus and any of the following complications: peripheral neuropathy with evidence of callus formation; or history of pre-ulceratic calluses;

or history of previous ulceration; or foot deformity; or previous amputation of the foot or part of the foot; or poor circulation (limited to one pair per plan year), rehabilitative when prescribed as part of post-surgical or post-traumatic casting care, prosthetic shoes that are an integral part of the prosthesis (limited to one pair per lifetime), and ankle orthotics, ankle-foot orthoses, and knee-ankle-foot orthoses. Such items will be covered when prescribed by a physician if medically necessary as determined by the claims administrator unless otherwise excluded.

32. Home health care when certified as medically necessary and preauthorized by the claims administrator. Covered services are limited to 125 visits per plan year for part-time or intermittent home nursing care given or supervised by a registered nurse. Home Health aide care is also covered, limited to 30 visits per plan year.
33. Ketogenic diet counseling when approved through case management.
34. Charges, including procedure charges, physician charges, and facility charges, for certain PET scans when determined to be medically necessary and approved by the claims administrator. (Members or physicians should verify medical necessity and benefit eligibility before incurring charges for use of the PET scan technology.)
35. Some surgical weight reduction procedures, including related services that are medically necessary. Five surgical procedures are covered: vertical banded gastroplasty accompanied by gastric stapling; gastric segmentation along the vertical axis with a Roux-en-Y bypass with distal anastomosis placed in the jejunum; gastric banding; gastric sleeve surgery (Vertical sleeve gastrectomy); and duodenal switch/biliopancreatic bypass procedure. Prior authorization is required. The Plan has very specific criteria which must be met before surgery will be covered. Please see the Bariatric Surgery section in this handbook for details.
36. Routine patient costs related to clinical trials as defined by TCA 56-7-2365.
37. Routine foot care for diabetics including toenail clipping and treatment for corns and calluses.
38. Hearing aids for dependent children under eighteen (18) years of age every three (3) years, including ear molds and services to select, fit and adjust the hearing aids.

Excluded Services and Procedures

1. Services provided by a participant's immediate family member, whether by blood, marriage, or adoption.
2. Services not ordered or furnished by an eligible provider.
3. Charges in excess of the maximum allowable charge when using out-of-network providers.
4. Experimental or investigational treatments, procedures, facilities, equipment, drugs, or supplies as initially determined by the claims administrator to not yet be recognized as acceptable medical practice or which require, but have not received, approval by a federal or other governmental agency. (Members are held harmless for charges or services from network providers unless they have signed a waiver accepting responsibility for the cost.)
5. Charges that would be considered a covered injury paid under workers' compensation, regardless of the presence or absence of workers' compensation coverage.
6. Comfort or convenience items.
7. Humidifiers, dehumidifiers, exercise devices, blood pressure kits, heating pads, sun or heat lamps.
8. Arch supports, corn plaster (pads, etc.), foot padding (adhesive moleskin, etc.) orthotic or orthopedic shoes and other foot orthoses (including inner soles or inserts) unless specified as covered expenses, foot orthoses primarily used for cosmetic reasons or for improved athletic performance or sports participation, and routine foot care including charges for the removal of corns or callus or trimming of toenails unless there is a diabetic diagnosis.
9. Hearing aids, including examinations and fittings, unless otherwise specified as covered expenses in this handbook or the Plan Document.
10. Midwife services outside a licensed health care facility.
11. Nonsurgical service for weight control or reduction, including prescription medication and weight loss programs. This exclusion does not apply to healthy diet counseling as described in the Covered Expenses section of this handbook or participation in an integrated clinical program as part of the bariatric surgery benefit.
12. Artificial or nonhuman organ transplants and related services, except for Ventricular Assist Devices (VAD) and Total Artificial Hearts (TAH) when determined to be medically necessary by the claims administrator.
13. Radial keratotomy, LASIK, or other procedures to correct refractive errors; eyeglasses, sunglasses, or contacts including examinations and fitting charges.
14. Surgery or treatment for, or related to, psychogenic sexual dysfunction or transformation.
15. Services or supplies in connection with fertility preservation, artificial insemination, in-vitro fertilization, or any procedure intended to create a pregnancy.
16. Wigs.
17. Ear or body piercing.
18. Custodial care, unapproved sitters, day and evening care centers (primarily for rest or for the elderly), or diapers.
19. Programs considered primarily educational and materials such as books or tapes.
20. Extraneous fees such as postage, shipping or mailing fees, service tax, stat charges, or collection and handling fees. Charges for telephone consultations.
21. Drugs and supplies which can be obtained without a prescription unless specifically cited in the covered expenses section of this handbook or the Plan Document.
22. Hotel charges unless pre-approved through the organ transplant program.
23. Cosmetic surgery and related expenses including, but not limited to, scar revision, rhinoplasty, and saline injection of varicose veins.
24. Any dental care, treatment, or oral surgery relating to the teeth and gums including, but not limited to, dental appliances, dental prostheses (such as crowns, bridges, or dentures), implants, orthodontic care, fillings, extractions, endodontic care, treatment of caries, gingivitis, or periodontal disease.
25. Treatment and therapies for maintenance purposes.
26. Reversal of sterilization procedures.
27. Charges incurred outside the United States unless traveling for business or pleasure.
28. Charges for bathroom chairs, stools and tub handrails.
29. Fitness clubs and programs.

How the Plan Works

Choice of Doctors

This plan does not require you to choose a primary care physician or PCP nor is there a required referral process for specialist services. The network is made up of physicians, hospitals, and other health care providers who have contracted with us to provide discounts to plan participants. In order to receive maximum benefits, you must use network providers.

While you are not required to select a primary care provider, you are encouraged to seek routine care from the same primary-type provider whenever possible for the purpose of establishing a medical home. A primary care provider can be a general practitioner, a doctor who practices family medicine, internal medicine, pediatrics, or an OB/GYN. Nurse practitioners, physician assistants, and nurse midwives may also be considered primary-type providers when working under the supervision of a primary care provider.

Members sometime have a need to see a specialist for a medical condition. Simply choose a specialist who participates in the network and schedule an appointment. If a network specialist determines that you should be admitted to the hospital or need services that require prior authorization, they will handle these plan requirements for you. However, it is a good idea to contact us to confirm benefits for hospital admissions or other services that require prior authorization.

Yearly Benefits

The Plan Year begins on January 1 and ends on December 31. Benefits reset each year. This means that if your doctor recommends that you have a certain service on an annual basis, that service will be covered once anytime within the plan year as long as the service is considered medically necessary, subject to any applicable plan limits.

Maternity Benefits

Coverage for maternity benefits involves an initial office visit copay for the purpose of verifying the pregnancy. Subsequent visits for routine care are covered under what is called “global billing.” These charges are included in the cost of labor and delivery. Should complications arise that require additional services of a specialist, additional charges will apply.

Plan Deductible

An annual deductible is the amount you pay each year before the plan pays for services that require coinsurance. After the deductible has been met, the plan pays a certain percentage of coinsurance for eligible expenses and you are responsible for the balance. Ineligible expenses, including amounts that exceed the maximum allowable charge, are not applied to the deductible. It is also important to note that there is an in-network deductible and an out-of-network deductible. The two deductibles add up separately. In-network charges cannot be applied to an out-of-network deductible, and out-of-network charges cannot be applied to an in-network deductible.

There is a separate deductible for pharmacy.

Out-of-Pocket Maximums

An out-of-pocket maximum limits how much you have to pay in any given year. If your spending reaches the out-of-pocket maximum, the plan pays 100 percent of your eligible expenses for the rest of the year.

It is important to note that there are separate out-of-pocket maximums for in-network and out-of-network expenses. As with the deductible, in-network charges cannot be applied to an out-of-network out-of-pocket maximum, and out-of-network charges cannot be applied to an in-network out-of-pocket maximum. Charges in excess of the maximum allowable charge and non-covered expenses do not count toward the out-of-pocket maximum.

Benefits: In-Network or Out-of-Network

In-network benefits are those provided by a network provider. You will pay a copay or percentage of the cost when you receive care. You can receive care from doctors and hospitals not participating in the network and benefits will be provided, but at a reduced level. If you utilize an out-of-network provider the cost to you will be substantial. You will receive the lower level of benefits and will be required to pay the difference between the maximum allowable charge (MAC) and the actual charge. Also remember certain services will not be covered out-of-network. Your health care coverage does not allow payment for services you receive in-network or out-of-network which are not medically necessary for your condition. If care given is not found to be appropriate and necessary, then no benefits will be available.

Maximum Allowable Charge Defined

In the simplest terms, the maximum allowable charge (MAC) is the maximum amount that we will pay to a particular provider for a particular service. Providers who have contracted with us to provide network services have agreed to accept that amount as payment in full, writing off the rest of the charge after any applicable deductible, coinsurance, or copayment is paid by the member.

Urgent Care

Members sometimes have a need for medical care during evenings or on weekends. “Urgent care” is care that is important, but does not result from a life-threatening condition. Urgent care health problems are usually marked by rapid onset of persistent or unusual discomfort associated with an illness. If you need urgent care, contact your doctor or specialist. Many physicians’ offices use an answering service after hours. When you call after regular hours, be prepared to describe your symptoms and leave a number where the doctor can call you back. Your doctor will offer advice and the best course of treatment for you. You also have the option to use an urgent care facility to seek treatment. You can conduct a provider search online or refer to a provider directory for urgent care facilities that you may use on weekends or after hours.

Examples of urgent care situations are:

- Difficulty in breathing
- Prolonged nose bleed
- Short-term high fever
- Cuts requiring stitches

Emergency Care

If you have a medical emergency, seek treatment at the nearest medical facility. Contact your doctor or our member service area within 24 hours if you are in the state of Tennessee or 48 hours if you are out-of-state. Your doctor will make arrangements for your follow-up care.

Use of the Emergency Room

The emergency room (ER) should be used only in the case of an emergency or in an urgent care situation when your doctor advises. The highest level of benefits is available for any emergency room visit that meets the following definition of an emergency. If out-of-network providers are utilized, you will not be responsible for amounts exceeding the allowable (maximum amount eligible for payment) unless it is determined that the situation was not an emergency or not medically necessary.

An "emergency" is a medical condition of sudden onset that manifests itself by symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual in serious jeopardy (or, with respect to pregnant women, the health of the woman or her unborn child)
- Serious impairment of bodily functions
- Serious dysfunction of any bodily organ or part

The prudent layperson approach is designed to address the issue of the need for a member to seek prompt access to care when symptoms appear serious.

For each covered emergency room visit, you will pay the emergency room copayment unless admitted for more than 23 hours or if the visit is a follow-up visit for the same episode of care within 48 hours of the initial visit to the emergency room. If you also receive services subject to coinsurance and deductible, such as an MRI or CT, you will be charged more. Should the ER require you to pay in full (not in-network), file the billing statement, along with a claim form, with our office and you will be reimbursed subject to the terms and conditions of the plan.

Hospitalization

If you need to be hospitalized, your doctor will make the necessary arrangements at a network facility. If you are admitted to a hospital (in-network or out-of-network) without our prior authorization, your benefits will be greatly reduced.

If you are out of the network service area or for some reason are unable to reach your doctor before seeking care, you should notify your doctor of any urgent care hospitalization within 24 hours (48 hours if you are out-of-state) of your admission. You should also notify your physician of emergency admissions within the same timeframe. This allows your doctor to make necessary arrangements for any follow-up care. If you have seen a specialist and need to be admitted to a hospital, your specialist will coordinate your hospital care with our office. Maternity admissions do not require pre-authorization.

Utilization Management

Utilization management (UM) programs include requirements governing pre-admission certification, post-certification of emergency admissions, weekend admissions, optional second surgical opinions, mandatory outpatient procedures, home health, case management, private duty nursing, durable medical equipment and the pharmacy program. These programs are used to determine payment of benefits. They are not meant to supersede the physician/patient relationship and the level and duration of medical care is always the patient's decision in conjunction with his/her physician.

Utilization Management (UM) decisions are based only on medical appropriateness of care and service and coverage eligibility. The UM organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care. Financial incentives for UM do not encourage decisions that result in underutilization.

Prior Authorization

Prior authorization is designed to encourage the delivery of medically necessary services in the most appropriate setting, consistent with medical needs of the member and with patterns of care of an established managed care environment for treatment of a particular illness, injury, or medical condition. Prior authorization is required for certain services including, but not limited to:

- Inpatient hospital services
- Skilled nursing facility stays
- Home health care
- Inpatient rehabilitation services
- 23 hour or less observation room stays
- Hospice
- Inpatient cardiac rehabilitation
- Home infusion therapy (certain drugs)
- Private duty nursing
- Advanced X-rays, Scans, and Imaging
- Durable Medical Equipment (only more expensive items)
- Same-day surgery procedures, including procedures at an ambulatory surgical center (does not apply to screening colonoscopy)

All providers for the above services should request these authorizations prior to services being rendered, except in the case of a maternity admission or an emergency situation. When a prior authorization is required, but not obtained, benefits for medically necessary services received out-of-network will be reduced by half, subject to the maximum allowable charge. No benefits will be paid for services which are not medically necessary or for services received from network providers who fail to obtain prior authorization.

BlueCross BlueShield of Tennessee does not manage prior authorization for pharmacy benefits or behavioral health and substance abuse treatment. Contact information for those programs is provided at the front of this handbook.

Advanced Radiological Imaging

BlueCross BlueShield of Tennessee will coordinate review of certain non-routine diagnostic services and the setting for such services in regards to medical appropriateness and necessity before the services are performed. Services subject to such review include Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Magnetic Resonance Spectroscopy (MRS), Computerized Tomography (CT), Computerized Tomography Angiography (CTA), Positron Emission Tomograpy (PET) scans, and nuclear cardiac imaging studies.

Durable Medical Equipment

The plan covers certain durable medical equipment (DME) determined to be medically necessary on the basis of an individual's medical and physical condition. Depending on the type of equipment needed, DME can be furnished on a rental basis or purchased. Types of equipment include blood glucose monitors and breathing equipment such as oxygen tanks, tents, regulators and flow meters. DME is not for comfort or convenience. Items are typically prescribed by a physician when recognized as therapeutic for a patient's diagnosis.

Please call our member services at 1-800-558-6213 with any questions.

Coordination of Benefits with Other Insurance Plans

If you are covered under two different insurance plans, benefits will be coordinated for reimbursement up to 100 percent of allowable charges. At no time should reimbursement be more than 100 percent of actual expenses. If you are covered as the subscriber or employee by more than one group health program, primary and secondary liability between the plans will be determined based on the order of benefit determination rules included in the Plan Document. Different coordination of benefit rules apply based on the type(s) of policies you may have and the status of those policies (e.g. active, retired, COBRA). If your spouse has coverage through his or her employer, and has you covered, then that coverage would be primary for your spouse and secondary for you. When this medical plan is primary, the benefits of this plan are calculated just as if the other plan did not provide benefits. Primary coverage on children is determined by which parent's birthday comes earliest in the calendar year. The insurance of the parent whose birthday falls last will be considered the secondary plan. The determination of primary or secondary coverage may be altered in the case of divorced parents when a court decree specifically designates the parent whose coverage will be primary. A copy of the court decree should be submitted to our office. If none of the above rules determines the order of benefits, the benefits of the plan which has covered an employee, member or subscriber longer are determined before those of the plan which has covered that person for the shorter time. For example, if a married dependent child under the age of 26 is covered by a parent under this plan and also has coverage under their spouse's plan, the primary plan will be the plan which has covered the dependent child for the longer period of time.

Once a year you will be asked to validate the information on file concerning other coverage. This is done because it is not uncommon for this type of information to change. Periodic validation helps us ensure accurate claims payments. The completed form letter must be received before any further claims processing can take place. You may also update this information on-line using the personalized and secure member website bcbst.com/members/tn_state.

Claims Subrogation

The medical plan has the right to subrogate claims. This means that the medical plan can recover (1) any payments made as a result of injury or illness caused by the action or fault of another person, or (2) a lawsuit settlement from payments made by a third party or insurer of a third-party. This would include automobile or homeowners insurance, whether yours or another's.

You are required to assist in this process and should not settle any claim without written consent from our subrogation department. Failure to respond to the plan's requests for information, and to reimburse the plan for any money received for medical expenses, may result in the covered person's disenrollment from the plan. Such disenrollment shall extend to any dependents who obtained coverage through the covered person. Any employee who has been disenrolled from the plan for failure to cooperate and pay outstanding medical expenses shall be ineligible to rejoin the plan for a period of three years.

Benefit Level Exceptions

Two types of exceptions — unique care and continuous care — may be granted for which benefits will be paid at the in-network level to an out-of-network provider or facility. Any charges above the maximum allowable charge are the patient's responsibility. All requests for exceptions are reviewed individually by BlueCross BlueShield. Exceptions will be granted only for medical necessity, not

for convenience. To apply for a unique or continuous care exception, work with your provider to submit the following information in a letter to BlueCross BlueShield, Attention State Unique Care Coordinator. Within two to three weeks, you will be notified whether your request is granted or denied. If the items listed below are not provided with the initial request, the decision may be delayed until all pertinent information can be gathered.

- Patient name and ID number
- Name and type of provider you are requesting
- Diagnosis and treatment plan, date(s) of service
- A statement explaining why this treatment cannot be received at a network facility or provided by a network physician

Unique Care Exceptions

A unique care exception can be granted for treatment not routinely available from a network provider in an employee's geographic area. This exception is based on the patient's condition or need for a particular physician and must be requested before receiving care. We will determine whether a network provider is available to provide treatment for the illness or injury.

If a unique care exception is granted, benefits are paid at the in-network level. Any charges above the maximum allowable are the patient's responsibility. If distance (out-of-state) traveling is required, reimbursement will be at 80 percent of commercial coach airfare or ground travel at the state approved mileage rate, if appropriate.

When unique care exceptions are granted, a time frame for this approval is given. If the need for unique care is anticipated beyond the stated time frame, then another unique care request must be submitted before the time frame is exceeded. Updated medical information documenting the continued need for out-of-network care will be required. The review of this request to extend a unique care approval will include an examination of the available network in an effort to determine if the required care can now be accessed within the network.

Continuous Care Exceptions

A continuous care exception can be granted when a patient is undergoing an active treatment plan for a serious medical condition, including pregnancy. This exception takes into account a patient's established relationship with an out-of-network provider. Our medical director will determine the time frame in which continuous care can be covered. Any charges above the maximum allowable are the patient's responsibility.

Coverage for Second Surgical Opinion Charges

In some instances, you have the option to receive a second surgical opinion. Second surgical opinions are not required. The second surgical opinion must be obtained from a surgeon qualified to perform the surgical procedure, but who is not in the same medical group as the physician who originally recommended surgery.

Charges for the second surgical opinion and any tests performed in obtaining the second surgical opinion will be paid at 100 percent of the maximum allowable charge if a network provider is used.

If you wish to obtain a second surgical opinion about a procedure not included on the list below, normal plan benefits and rules apply. Any surgeries (including those listed) must be medically necessary to be approved.

- Bone and joint surgery of the foot
- Cataract extraction with and without implant
- Cholecystectomy
- Hysterectomy
- Knee surgery
- Septoplasty/sub-mucous resection
- Prostatectomy
- Spinal and disc surgery
- Tonsillectomy and adenoidectomy
- Mastectomy
- Elective C-section

Case Management

Case management is a program that promotes quality and cost effective coordination of care for members with complicated medical needs, chronic illnesses, and/or catastrophic illnesses or injuries. Members who need case management are identified and contacted by phone or in writing regarding alternative treatment plans. Members or providers may also contact member service if they believe they would benefit from case management.

Filing Claims

Our office is responsible for all medical plan claims processing. When you visit a network doctor or facility, be sure to show your identification card. The provider will file your claim directly. These network providers must file your claim within six months of the date of service. All questions regarding claims, including requests for claim forms, should be addressed to member service.

If you visit an out-of-network doctor or facility, you may be responsible for filing claims. Out-of-network providers may also

require payment in full at the time of service. The appropriate form must be used and a separate claim form must be completed for each individual who has received services. More than one bill can be submitted on a claim form. For out-of-network providers, you have 13 months from the date of service to file claims and be eligible for reimbursement.

Our office is not responsible for processing claims for pharmacy or behavioral health and substance abuse treatment. See contact information at the front of this handbook for those programs.

Out-of-State Providers

Members who live outside of Tennessee still have access to network providers through our national network. Use the following steps to search for an out of state provider. Go to bcbst.com, click on Find a Doctor or Hospital, enter your three letter prefix located on your member identification card and enter the search criteria.

Out-of-Country Care

When traveling outside of the United States for business or pleasure, eligible expenses incurred for medically necessary emergency and urgent care services are covered at the in-network level. Other medically necessary care will be covered at the out-of-network level. No benefits will be paid if a covered person travels to another country for the purpose of seeking medical treatment outside the United States. Claims from a non-English speaking country should be translated to standard English at the covered person's expense. Claim forms should contain valid procedure and diagnosis codes and include the current exchange rate, if available, before being submitted for payment.

When you need health care outside the U.S., follow these simple steps:

1. Always carry your BlueCross BlueShield of Tennessee identification card.
2. Check with member services at 1-800-558-6213 before leaving the U.S.
3. If you need emergency medical care, go to the nearest hospital. Call the BlueCard Worldwide℠ Service Center at 1-800-810 BLUE (2583) or call collect at 1-804-673-1177 if you are admitted.
4. If you need non-emergency medical care, you must call the BlueCard Worldwide Service Center. The Service Center will facilitate hospitalization at a BlueCard Worldwide hospital or make an appointment with a doctor. It is important that you call the BlueCard Worldwide Service Center in order to get cashless access for inpatient care. The Service Center is staffed with multilingual representatives and is available 24 hours a day, seven days a week.

BluePerks Discount Program

BluePerks offers members discounts on products and services that help them lead a healthy balanced life. Discounts include:

- Gym memberships
- Weight loss programs
- Massages/spa services
- Vitamins and dietary supplements
- Yoga
- LASIK corrective eye surgery
- Eye care exams and products not covered by your health plan
- Hearing exams and hearing aid technology not covered by your health plan
- Fitness gear and equipment
- Regional family attractions
- Healthy foods/groceries

Members must pay the whole cost of all services they get through the BluePerks program. The terms and conditions of the Member's health plan do not apply to these services.

Bariatric Surgery Criteria

The plan will cover five surgical procedures for the treatment of morbid obesity:

- vertical banded gastroplasty accompanied by gastric stapling
- gastric segmentation along the vertical axis with a Roux-en-Y bypass with distal anastomosis placed in the jejunum
- gastric banding
- gastric sleeve surgery (vertical sleeve gastrectomy)
- duodenal switch/biliopancreatic bypass procedure, which is appropriate only for persons with a body mass index (BMI) in excess of 60 kg/m_2

In addition to being at least 18 years of age, members must meet ALL of the following five medical necessity criteria in order for the plan to cover their bariatric procedures:

1. **Presence of morbid obesity that has persisted for at least one year, defined as either:**
   (a) class 3 obesity (BMI equal to or greater than 40 kg/m_2), or (b) class 2 obesity (BMI 35 to 39.9 kg/m_2) in conjunction with clinically significant co-morbidities (recognized by National Institutes of Health as likely to reduce life expectancy): coronary artery disease; or type 2 diabetes mellitus; or obstructive sleep apnea; or three or more of the following cardiac risk factors:
   - Hypertension (blood pressure greater than 140 mmHg systolic and/or 90mmHg diastolic)

- Low high-density lipoprotein cholesterol (HDL less than 40mg/dL)
- Elevated low-density lipoprotein cholesterol (LDL greater than 100 mg/dL)
- Current cigarette smoking
- Impaired glucose tolerance (two-hour blood glucose greater than 140 mg/dL on an oral glucose tolerance test)
- Family history of early cardiovascular disease in first-degree relative (myocardial infarction at or before 55 years of age in male relative or at or before age 65 for female relative)
- Age greater than 45 years in men and 55 years in women

(c) BMI exceeding 60 for consideration of the duodenal switch/biliopancreatic bypass procedure.

2. **History of failure of one or more medically appropriate medical/dietary therapies** such as low calorie/low fat diet, increased physical activity, behavioral reinforcement, or pharmacotherapy in conjunction with at least one other therapy. This attempt at conservative management must be within two years prior to surgery, and must be documented by an attending physician who does not perform bariatric surgery. Failure of conservative therapy is defined as an inability to lose more than ten percent of body weight over a six-month period and maintain weight loss.

   Adequate documentation includes but is not limited to physician or other health care provider notes and/or participation logs from a structured weight loss program.

3. **Documentation of medical evaluation of the individual for the condition of morbid obesity and/or its co-morbidities** by a physician other than the operating surgeon and his/her associates (including documentation that this evaluating physician concurs with the recommendation for bariatric surgery).

4. **Documentation from psychologist or psychiatrist** regarding individual's capacity to comply with both pre- and postoperative treatment plans.

5. **Benefits Administration may also require active participation in an integrated clinical program** that involves guidance on diet, physical activity and behavioral and social support prior to and after the surgery. The claims administrator will determine if all the criteria have been met before approving surgery.

   Only Centers of Excellence shall perform all bariatric procedures (weight reduction surgeries). Centers of Excellence include facilities with this designation from either the insurance carrier, the American Society for Metabolic and Bariatric Surgery (ASMBS), the American College of Surgeons (ACS), or the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP). **Remember, services received from out-of-network providers will cost more than services received from in-network providers.**

Pharmacy Benefits

Three levels of benefits are available for prescription drugs, and your choice determines the copayment amount you pay each time you have your drugs dispensed by a participating network pharmacy.

- Generic drugs are in the first tier and offer the best value. When your doctor writes your prescription, ask about using a generic drug. Generics are safe, effective, and affordable alternatives to brand name drugs, and are available in many instances.
- Preferred brands are in the second tier. If a generic alternative is not available, talk to your doctor about prescribing a brand-name drug from the preferred drug list. This list includes many popular brand-name drugs.
- Non-preferred brands are in the third tier and will cost you the highest copayment.

When a generic is available and the member's physician has indicated "may substitute" but the pharmacy dispenses the brand name **based on the member's request**, the member will pay the difference between the brand name drug and the generic drug **plus** the brand copay.

Pharmacy benefits are administered by CVS/caremark and not BlueCross BlueShield of Tennessee. Please call 1-877-522-8679 for further information or visit info.caremark.com/stateoftn. Once there, register to view the State of Tennessee Group Insurance Program Prescription Drug List, Specialty Drug List, a listing of Vaccine Network Pharmacies, and pharmacies participating in the Retail 90 Network, where you can fill prescriptions for up to a 90 day supply for the applicable plan copayment. Please note that any medication classified as a specialty medication can only be filled for a 30 day supply and must be filled through a pharmacy in the CVS/caremark Specialty Network.

Behavioral Health and Substance Abuse Benefits

Employees and their dependents enrolled in health coverage are eligible for behavioral health and substance abuse benefits, which are administered by Magellan. Services generally include the following:

- Outpatient assessment and treatment
- Inpatient assessment and treatment
- Alternative care such as partial hospitalization, residential treatment and intensive outpatient treatment
- Treatment follow-up and aftercare

- Certain services are specifically excluded under the terms and conditions of the state group insurance program. For more information, contact Magellan.

To receive maximum benefit coverage, participants must use a network provider and obtain prior authorization for inpatient services as well as some outpatient services including psychological testing and electroconvulsive therapy. Magellan can be reached toll-free at 1-855-437-3486 any time, day or night, to speak confidentially with a trained professional for a referral. Out-of-network behavioral health benefits are available; however, coinsurance and copayments will be higher. Participants are also subject to balance billing by the out-of-network provider meaning that they will pay the difference between the maximum allowable charge and the actual charge. Additionally participants are at risk of having inpatient benefits totally denied.

Eligible individuals also have access to an Employee Assistance Program (EAP) that provides up to five counseling sessions, per incident, at no cost to them. In addition to counseling support, your EAP provides a variety of consulting services including financial, legal, childcare, eldercare, and identity theft support. Prior authorization is required to see an EAP provider and can be obtained by either logging on to www.Here4TN.com or calling 1-855-437-3486. The website provides valuable health information, tools and resources to help with life's challenges as well as opportunities. This site offers you the ability to take self-assessment tests, on-line trainings, search for available providers and access a map of your provider's location, as well as obtain driving directions. You may set up your own unique account number and password for confidential and anonymous access to a wide variety of information and resources including the ability to view claims information online.

Magellan also has its own policies and procedures to protect your privacy. These policies guide Magellan staff, providers, and visitors on how to keep information private. By signing Magellan's Authorization to Use or Disclose Protected Health Information Form, you permit Magellan to disclose your personal information. If you have a guardian or someone selected by the court, they can sign the form for you. Magellan can only give your information to you or the designated person. To get an Authorization to Use or Disclose Protected Health Information Form, please call 1-855-437-3486.

ParTNers for Health Wellness Program

The ParTNers for Health wellness program is free to all eligible plan members and their covered dependents. Services are administered by Healthways. Call 1-888-741-3390 for more information. The program features the following benefits:

- **24/7 Nurse Advice Line** – Provides information and support 24 hours a day, 7 days a week.
- **Health Coaching** – Coaches are available to help you reach your personal health goals as well as better manage your chronic health conditions.
- **Health Screenings** – Provides you with an easy-to-access way of getting important health information that will give you insight into your current health status and opportunities to reduce future health risks.
- **Online Resources** – A website which provides online tools and health information as well as access to the online Healthways Well-Being Assessment (health questionnaire).
- **Well-Being Plan** – Once you complete the Well-Being Assessment, you will view your results and create your own personal Well-Being Plan, which will help you set goals and focus on areas where you can make improvements.
- **Weekly Health Tips** – Members can sign up to receive email tips on healthy living.

Member
Rights and Responsibilities

Member Rights

You have the right to:

- Be treated with respect and dignity.
- Expect that any information you give will be treated in a confidential manner.
- Information about policies and services of the plan.
- Information regarding network providers.
- Medically necessary and appropriate medical care.
- Information about your health.
- Make decisions about your health care with practitioners.
- Voice complaints about your health care providers, the care given to you, or the PPO plan. You can expect an answer within a reasonable time. You also have the right to formally appeal this answer if you do not agree.
- A candid discussion of appropriate or medically necessary care options for your condition, regardless of cost or benefit coverage.

Confidentiality and Privacy

Your health is your own private business. Be assured that we will treat your medical records and claims payment history in a confidential manner. When you enroll in the plan, you give routine consent for certain matters. That allows the company to release information without your prior written consent for these purposes:

- Claim processing.
- Performing peer review, utilization review, and medical audits.
- Administration of programs established by us for quality health care and control of health care costs.
- Medical research and education.

Important steps are taken to protect your privacy.

- Employees have been trained to understand the importance of safeguarding your privacy. In fact, they sign confidentiality agreements to ensure they will carry out the established policies.
- Contracted practitioners and providers follow confidentiality guidelines set forth by the state in which they practice.
- Vendors must sign confidentiality agreements if they receive personal health information for purposes of plan administration such as measurement of data to improve quality.
- It is the policy not to release member-specific health information to employers unless allowed by law.
- Members have the right to approve the release of personal health information in special circumstances beyond those listed above.

Members can take comfort in knowing that confidentiality is important. You are encouraged to call one of the member service representatives if you have questions about privacy policies and practices.

Women's Health and Cancer Rights Act

Your medical plan's coverage of a medically necessary mastectomy also includes post-mastectomy coverage for reconstruction of the breast, surgery on the other breast to achieve the appearance of symmetry, prostheses, and physical complications during any stage of the mastectomy, including lymphedemas. This coverage will be provided in consultation with the attending physician and patient. Benefits are subject to the same annual deductibles and coinsurances as other services.

Member Responsibilities

Members are responsible for:

- Reading the member materials in their entirety and complying with the rules and limitations as stated.
- Contacting in-network providers to arrange for medical appointments as necessary.
- Notifying in-network providers in a timely manner of any cancellations of appointments.
- Paying the coinsurance and deductibles as stated in the benefit plan documents at the time service is provided.
- Receiving prior authorization for services when required, and complying with the limits of the prior authorization.
- Carrying and using their plan identification card and identifying themselves as a plan member prior to receiving medical services.
- Using in-network providers consistent with the applicable benefit plan.
- Providing, to the extent possible, information needed by professional staff in order to care for the member.
- Following instructions and guidelines given by those providing health care services.

Appeal Procedures

If you experience a problem relating to the plan policies or the services provided, there are established internal and external procedures to help you resolve your complaint. These procedures do not apply to any complaint or grievance alleging possible professional liability, commonly known as malpractice, or for any complaint or grievance concerning benefits provided by any other plan.

Specific questions regarding initial levels of appeal (the internal appeal process) should be directed to the claims administrator member service numbers provided below. Other appeal questions may be directed to the Benefits Administration appeals coordinator at 615-741-4517 or 1-866-576-0029.

Administrative Appeal

To file an appeal regarding an administrative process or decision (e.g., transferring between health plans, effective dates of coverage issues, or timely filing issues) contact your agency benefits coordinator.

Behavioral Health and Substance Abuse Appeals

Contact Magellan at 1-855-437-3486 for EAP, behavioral health and substance abuse appeals.

Pharmacy Appeals

Contact CVS/caremark at 1-877-522-8679 for pharmacy appeals.

Medical Service Appeals

If you are in disagreement with a decision or the way a claim has been paid or processed, you or your authorized representative should first call member service at 1-800-558-6213 to discuss the issue. If the issue cannot be resolved through member service, you may file a formal request for internal review or member grievance by completing the appropriate form or as otherwise instructed. All requests must be filed within the specified timeframe. When your request for review or member grievance is received, you will get an acknowledgement letter advising you what to expect regarding the processing of your grievance. Once a determination is made, you will be notified in writing and advised of any further appeal options, including external consideration by an Independent Review Organization (IRO).

If a denial of coverage or authorization can reasonably be expected to prevent a covered individual from obtaining urgently needed covered services (e.g., emergency or life threatening procedures), then providers may request an expedited reconsideration. If the treating provider or primary care physician fails to request the reconsideration and decides not to provide urgently needed services, then the member, or someone acting on the member's behalf, may request the expedited reconsideration. If BlueCross BlueShield agrees that it is appropriate to conduct an expedited reconsideration, we will inform the member of our decision as quickly as possible based on the circumstances of the care, including the ability to obtain information concerning the case from the provider.

Please Note: The expedited reconsideration process is only applicable in situations where a benefit determination or a prior authorization denial has been made prior to services being received.

Q&A

Q Is my child who is attending college out of state covered at the network level?

A Children attending college out of the service area should utilize the BlueCard PPO program when receiving medical services. The BlueCard PPO program links PPO network providers from Blue Plans across the United States. Please refer to the BlueCard PPO section of this handbook for specific information.

Q Other than the benefit level, are there other differences if I use out-of-network providers?

A Out-of-network providers can bill you for any difference between actual charges and the maximum amount allowed by the plan plus any services deemed not medically necessary or not authorized. When you use an out-of-network provider, the charges for which you are responsible may be substantial.

Q Do I have a choice of hospitals?

A We have contracted with certain hospitals to provide care to you. If specialty care is not available at the contracted hospital(s), arrangements will be made to the appropriate non-network hospital. A request for unique care benefits may be required.

Q What happens if my doctor disagrees with a medical policy regarding my covered treatment alternatives?

A A provider appeals process is available for this situation.

Q What if my physician is out of the office?

A Physicians "cover" for each other on a rotating schedule. This means there may be times when you will not be able to speak with your physician. The nurse or physician on call will be able to help you.

Q What if I must reach my physician after regular office hours?

A Most physician offices utilize an answering service; therefore, when you call after regular office hours, you will most likely talk to a representative from the answering service. The on-call health care professional will request some identifying information and will need a general description of your urgent medical need.

Find benefit details in an instant.

Use your State member pages and BlueAccess℠ anytime at bcbst.com/members/TN_state

- Review your claims and explanation of benefits
- Order replacement or additional identification cards
- Access your Personal Health Manager

of Tennessee

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