**NEW THIS YEAR.** Member handbooks are going green! We’re reducing paper and conserving resources by moving from five handbooks to one.

Your combined handbook tells you what you need to know about ALL medical plans sponsored by the State of Tennessee Group Insurance Program. Those plans include the Premier PPO, Standard PPO, Limited PPO, CDHP/HSA and Local CDHP/HSA.

**Make sure you know the name of the plan you’ve chosen, and pay special attention when that plan is mentioned.** Much of the information in this handbook, like covered and excluded services, applies to all plans. Some of the information, like what services will cost you, is specific to the plan you’re enrolled in. You’ll see plan names mentioned when information is plan-specific.

**Want a coverage summary you can hold in the palm of your hand?** Take a look at your Member ID card. It has the name of your plan, your cost for common services, your plan’s network and important phone numbers. See a sample Member ID card on page 4.

---

**Important Notice**

This member handbook explains many features of your health care coverage.

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 ParTNers for Health website contains an electronic version of this handbook and many other important publications, including a Summary of Benefits and Coverage (SBC) and a Plan Document. The Plan Document is the official legal publication that defines eligibility, enrollment, benefits and administrative rules of the state group insurance program. Copies are available for your review from your agency benefits coordinator or from the State of Tennessee Benefits Administration website at https://www.tn.gov/partnersforhealth.html.

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, national origin, sex, age or disability in its health programs and activities. If you have a complaint regarding discrimination, please call 866-576-0029 or 615-741-4517.
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Welcome

State, higher education, local education and local government members:

Thank you for choosing BlueCross BlueShield of Tennessee. We’ve been working in Tennessee for more than 70 years to provide quality, affordable health care. Today, more than three million people across the state turn to us for health care coverage.

We’re also part of the Blue Cross Blue Shield 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. So no matter where you live, work or travel, you can find a network provider when you need care. We’re right here to answer any questions, help you understand your coverage and make sure you get the care you need.
Member ID Cards

You have ID cards for yourself and each of your covered dependents. All cards will have your name as the employee or head of contract. The cards show the name of your selected health option and a reminder that the network for your plan is Blue Network SM. Review this information carefully and call if you have any questions.

See your actual Member ID card.

The name of your plan will appear in this field. You’ll see one of the following:
- Premier PPO
- Standard PPO
- Limited PPO
- CDHP/HSA
- Local CDHP/HSA

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 may 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.

Adding Dependents

If you want to add dependents to your coverage, you must provide documentation verifying the dependents’ eligibility to Benefits Administration. A list of acceptable documents is available from your agency benefits coordinator or the ParTNers for Health website.
Important Contact Information

We’re here to answer any questions about your health coverage or specific health care claims. Call member services to speak with someone who can explain how your specific benefits and coverage work. You’ll need your Member ID card when you call.

BlueCross BlueShield of Tennessee
Member Services: 800-558-6213, 7 a.m. – 5 p.m. (CST) M-F
Report Fraud: 888-343-4221
Transplant Coordinator: 888-207-2421

Find in-network providers while traveling:
• Anywhere in the United States, call 800-810-BLUE (2583) or visit bluecard.com.
• Anywhere outside the United States, call 800-810-BLUE (2583) toll-free or 804-673-1177 collect, or visit bcbsglobalcore.com.

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

Here4TN Behavioral Health, Substance Use and Employee Assistance
Optum Health
855-Here4TN (855-437-3486)

Pharmacy
CVS/caremark
877-522-8679

ParTNers for Health Wellness Program
888-741-3390
http://goactivehealth.com/wellnesstn

Member Portal

You can also find useful information and resources anytime at bcbst.com/members/TN_state.

In addition to finding providers online, you can check your benefits and claim status or find a weight loss program or a nearby walking trail in Tennessee.

More details can make you a better buyer – of anything. Health care is the same. Our website gives you tools and facts to help you take charge of your health plan.

The Find Care section helps you learn about the cost of care so you can make better choices with your health care options. These tools and links include:

• Find a Doctor
• HealthCare Cost Estimator
• Claims and Coverage Lookup
• Treatment Options
• Personal Health Statement

New tools are added all the time, so check back often.

Check plan details, claims, EOBs and other plan details through BlueAccess™
Sign up for a username and password to start using BlueAccess, the secure area of bcbst.com. It’s easily accessible from your smartphone, tablet or computer. Through BlueAccess, you can:

• Check your benefits, including applied deductibles and out-of-pocket limits
• Check the status of a medical claim you filed
• View your explanation of benefits (EOB) forms online and subscribe to the email EOB notice service
• Find health tools to help you make better health care choices
Cost Sharing
The term “cost sharing” means your share of costs, or what you must pay out of your own pocket, for services covered by your health plan. Sometimes these costs are called “out-of-pocket” costs. Some examples of cost sharing are copayments, deductibles and coinsurance. Other costs, including your premiums or the cost of care not covered by your plan, aren’t considered cost sharing.

A **copayment** (or copay) is a fixed amount you pay for a covered health care service, usually when you receive the service. An example of a copayment is $25.

**Coinsurance** is your share of the cost of a covered health care service, calculated as a percentage. An example of coinsurance is 20 percent of the allowed amount for a service. Generally, if coinsurance applies to a health care service, you will have to “meet” or “satisfy” a deductible first. In other words, you will pay your deductible **plus** coinsurance.

A **deductible** is the amount you owe during the plan year for covered health care services before your plan begins to pay. A deductible applies to some services under the state-sponsored preferred provider organization (PPO) plans and almost all services under the state-sponsored consumer-driven health plan (CDHP)/health savings account (HSA) plans.

Copayment, coinsurance, and deductible amounts vary depending on the plan you’re enrolled in and the type of services you receive.

You have benefits and separate cost-sharing amounts for eligible services from both in-network and out-of-network providers. Your cost sharing is less for in-network care. See the benefit grids in this handbook for additional details and look for information specific to your plan.

**PPO Plans**
Your PPO plan is a preferred provider organization plan. It requires that you pay either a copayment or a deductible and coinsurance for covered services.

Whether you’re enrolled in the Premier PPO, the Standard PPO, or the Limited PPO:

- In-network preventive care (annual well visit and routine screenings) is covered at no cost to you.
- You pay copays for other covered services like office visits to primary care providers and specialists, behavioral health and substance use services, telehealth, visits to convenience clinics, urgent care facilities, emergency rooms and most prescription medications.
- You pay deductible and coinsurance for things like inpatient hospital care, outpatient surgery, X-rays, labs and diagnostic tests, ambulance services and durable medical equipment.

**CDHP Plans**
Your consumer driven health plan (CDHP) or High Deductible Health Plan (HDHP) includes a tax-free health savings account (HSA), which you own and can use to pay for qualified medical expenses, including some that may not be covered by your health insurance plan (like vision and dental expenses, hearing aids, contact lens supplies and more). More information follows in the HSA section of this handbook.

Whether you’re enrolled in the CDHP/HSA or the Local CDHP/HSA:

- In-network preventive care (annual well visit and routine screenings) is covered at no cost to you.
- You pay coinsurance for ALL other covered services.
- You must meet your deductible before the plan starts paying for covered expenses, EXCEPT for in-network preventive care and 90-day supply maintenance medications (e.g., hypertension, diabetes, depression, statins used to treat high cholesterol, etc.).
- Your coinsurance cost for prescription medications is a percentage of the discounted network rate for prescriptions after the deductible is met. You pay for the medication at the discounted network cost until your deductible is met — then you pay coinsurance.
• If you buy your prescriptions by mail order and want to use your HSA funds to pay, you must provide caremark with your HSA debit card number before the prescription is processed and shipped. Otherwise, caremark will charge the order to the credit card they have on file.

Health Savings Account (HSA)

When you enroll in the CDHP, a HSA will be opened for you automatically. The HSA is managed by PayFlex, a company selected and contracted by the state. Contact information is included in the front of this handbook. You own your HSA account, and it is your responsibility to register for your online account access at stateoftn.payflexdirect.com. The state will pay the monthly maintenance fee for your HSA while you are enrolled in the state’s CDHP. You are responsible for standard banking fees such as non-sufficient funds, stop payments, overdrafts and investment fees. If you leave your job, retire or choose a PPO option in the future, you become responsible for paying the monthly maintenance HSA fees, and these will be deducted from your HSA automatically.

You and your employer may contribute to your HSA. The money saved in your HSA (both yours and any employer contributions, if offered) rolls over each year and collects interest. You don’t lose it at the end of the year. The money is yours! You take your HSA with you if you leave or retire.

• If you have questions about employer contributions, contact your human resources office or your agency benefits coordinator.

• You can contribute money to your HSA through online bank transfer or by mailing a check.

• In 2019, IRS guidelines allow total annual tax-free contributions up to $3,500 for those with single coverage and $7,000 for those with any other coverage. At age 55 and older, you can make an additional $1,000/year contribution ($4,500 for individuals or $8,000 for families). The maximum includes any employer contribution.

You can use money in your account to pay your deductible and qualified medical, behavioral health, vision and dental expenses. Once funds are available in your HSA, PayFlex makes it easy to pay for your eligible expenses.

• Use the PayFlex Card® — your account debit card. It’s a convenient way to pay for eligible expenses. Expenses are paid automatically, as long as funds are available. If you have family coverage, additional debit cards may be ordered online or by phone.

• Use PayFlex’s online feature to pay your provider directly from your account.

• Pay yourself back: Pay for eligible expenses with cash, check or your personal credit card. Then withdraw funds from your HSA to pay yourself back. You can even have your payment deposited directly into your linked checking or savings account.

PayFlex Free Mobile App

• This app makes it easy for you to manage your account virtually 24/7. It’s available for iPhone® and iPad® mobile digital devices, Android® and BlackBerry® smartphones. It will give you access to your online account, to transfer funds, make payments or view a list of qualified medical expenses. It even lets you upload photos of your receipts for qualified expenses to keep for tax purposes.

• Both employee and employer contributions (if offered) are tax free. Withdrawals for qualified medical expenses are tax free. Interest accrued on your HSA balance is tax free.

Note: Payroll deductions are made before tax. Contributions made directly from employees’ bank accounts need to be recorded as a tax deduction.

You can find more details about your CDHP and a list of frequently asked questions (FAQ) on the ParTNers for Health website at https://www.tn.gov/partnersforhealth.html.
## Table 1: PPO PLANS

Services in this table **ARE NOT** subject to a deductible. $ = your copayment amount; % = your coinsurance percentage; 100% covered = you pay $0 in-network. The Limited is open to Local Education and Local Government members only.

<table>
<thead>
<tr>
<th>PPO HEALTH CARE OPTION</th>
<th>PREMIER</th>
<th>STANDARD</th>
<th>LIMITED</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COVERED SERVICES</strong></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td><strong>Preventive Care Office Visits</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well-baby, well-child visits as recommended</td>
<td>No Charge</td>
<td>$45</td>
<td>No Charge</td>
</tr>
<tr>
<td>Adult annual physical exam</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual well-woman exam</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunizations as recommended</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual hearing and non-refractive vision screening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screenings including Pap smears, labs, nutritional guidance, tobacco cessation counseling and other services as recommended</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Services</strong></td>
<td>Services subject to a coinsurance may be extra</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Primary Care Office Visit</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family practice, general practice, internal medicine, OB/GYN and pediatrics</td>
<td>$25</td>
<td>$45</td>
<td>$30</td>
</tr>
<tr>
<td>Nurse practitioners, physician assistants and nurse midwives (licensed health care facility only) working under the supervision of a primary care provider</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Including surgery in office setting and initial maternity visit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Specialist Office Visit</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse practitioners, physician assistants and nurse midwives (licensed health care facility only) working under the supervision of a specialist</td>
<td>$45</td>
<td>$70</td>
<td>$50</td>
</tr>
<tr>
<td><strong>Behavioral Health and Substance Use</strong> (including virtual visits)</td>
<td>$25</td>
<td>$45</td>
<td>$30</td>
</tr>
<tr>
<td><strong>Telehealth</strong> (approved carrier programs only)</td>
<td>$15</td>
<td>N/A</td>
<td>$15</td>
</tr>
<tr>
<td><strong>Allergy Injection Without Office Visit</strong></td>
<td>100% covered</td>
<td>100% covered up to MAC</td>
<td>100% covered</td>
</tr>
<tr>
<td><strong>Chiropractic</strong> (limit of 50 visits per year)</td>
<td>Visits 1-20: $25 Visits 21-50: $45</td>
<td>Visits 1-20: $30 Visits 21-50: $70</td>
<td>Visits 1-20: $50 Visits 21-50: $75</td>
</tr>
<tr>
<td><strong>Convenience Clinic</strong></td>
<td>$25</td>
<td>$45</td>
<td>$30</td>
</tr>
<tr>
<td><strong>Urgent Care Facility</strong></td>
<td>$45</td>
<td>$70</td>
<td>$50</td>
</tr>
<tr>
<td><strong>Emergency Room Visit</strong></td>
<td>$150</td>
<td>$175</td>
<td>$200</td>
</tr>
<tr>
<td><strong>Pharmacy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>30-Day Supply</strong> (generic</td>
<td>preferred brand</td>
<td>non-preferred)</td>
<td></td>
</tr>
<tr>
<td>30-day supply from a specialty network pharmacy</td>
<td>$7</td>
<td>$40</td>
<td>$90</td>
</tr>
<tr>
<td><strong>90-Day Supply</strong> (generic</td>
<td>preferred brand</td>
<td>non-preferred)</td>
<td></td>
</tr>
<tr>
<td>90-day network pharmacy or mail order</td>
<td>$14</td>
<td>$80</td>
<td>$180</td>
</tr>
<tr>
<td>Certain maintenance medications from 90-day network pharmacy or mail order</td>
<td>$7</td>
<td>$40</td>
<td>$180</td>
</tr>
<tr>
<td><strong>Specialty Medications</strong> (30-day supply from a specialty network pharmacy)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network for all plans = 10%; minimum $50; maximum $150</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-Network for all plans = NA – no network</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Table 2: PPO PLANS - Services in this table ARE subject to a deductible unless noted with a [5]. % = your coinsurance percentage. The Limited is open to Local Education and Local Government members only.

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Premier</th>
<th>Standard</th>
<th>Limited</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive Care – Outpatient Facilities</strong></td>
<td>In-Network[1]</td>
<td>Out-of-Network[1]</td>
<td>In-Network[1]</td>
</tr>
<tr>
<td>Screenings including colonoscopy, mammogram, colorectal, bone density scans and other services as recommended</td>
<td>No Charge</td>
<td>40%</td>
<td>No Charge</td>
</tr>
<tr>
<td><strong>Other Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital/Facility Services</strong>[4]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient care; outpatient surgery</td>
<td>10%</td>
<td>40%</td>
<td>20%</td>
</tr>
<tr>
<td>Inpatient behavioral health/substance use[2]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maternity</strong> (Global billing for labor and delivery and routine services beyond initial office visit)</td>
<td>10%</td>
<td>40%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Home Care</strong>[4] (Home health; home infusion therapy)</td>
<td>10%</td>
<td>40%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Rehabilitation and Therapy Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient and skilled nursing facility[4]; outpatient</td>
<td>10%</td>
<td>40%</td>
<td>20%</td>
</tr>
<tr>
<td>Outpatient IN-NETWORK physical, occupational and speech therapy[3]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>X-Ray, Lab and Diagnostics</strong> (not including advanced X-rays, scans and imaging)[3]</td>
<td>10%</td>
<td>40%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Advanced X-Ray, Scans and Imaging</strong> (including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies)[4]</td>
<td>10%</td>
<td>40%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>All Reading, Interpretation and Results</strong>[5]</td>
<td>10%</td>
<td>40%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Ambulance</strong> (air and ground)</td>
<td>10%</td>
<td>40%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Equipment and Supplies</strong>[4]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment and external prosthetics</td>
<td>10%</td>
<td>40%</td>
<td>20%</td>
</tr>
<tr>
<td>Other supplies (i.e. ostomy, bandages, dressings)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Also Covered</strong></td>
<td>Certain dental benefits, hospice care and out-of-country charges – See separate sections in this handbook for details</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Deductible**

<table>
<thead>
<tr>
<th></th>
<th>Employee Only</th>
<th>Employee + Child(ren)</th>
<th>Employee + Spouse</th>
<th>Employee + Spouse + Child(ren)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premier</td>
<td>$500</td>
<td>$1,000</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>Standard</td>
<td>$1,000</td>
<td>$2,000</td>
<td>$2,000</td>
<td>$4,000</td>
</tr>
<tr>
<td>Limited</td>
<td>$2,000</td>
<td>$4,000</td>
<td>$4,000</td>
<td>$8,000</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>$3,600</td>
<td>$6,000</td>
<td>$6,600</td>
<td>$13,600</td>
</tr>
<tr>
<td>Employee Only</td>
<td>$6,800</td>
<td>$12,000</td>
<td>$12,000</td>
<td>$20,800</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$10,400</td>
<td>$20,800</td>
<td>$20,800</td>
<td>$41,600</td>
</tr>
</tbody>
</table>

**Out of Pocket Maximum**

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 (MAC) will not be counted. 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.

\[1\] Subject to maximum allowable charge (MAC). The MAC is the most a plan will pay for a covered service. For non-emergent care from an out-of-network provider who charges more than the MAC, you will pay the co-pay or coinsurance PLUS the difference between MAC and actual charge.

\[2\] The following behavioral health services are treated as “inpatient” for the purpose of determining member cost-sharing: residential treatment, partial hospitalization/day treatment programs and intensive outpatient therapy. In addition to services treated as “inpatient,” prior authorization (PA) is required for certain outpatient services, such as psychological testing, transcranial magnetic stimulation, electro-convulsive treatment, extended outpatient treatment visits beyond 45-50 minutes in duration with or without medication management, and Applied Behavior Analysis.

\[3\] Applies to certain antihypertensives for coronary artery disease (CAD) and congestive heart failure (CHF); oral diabetic medications, insulin and diabetic supplies; statins; medications for asthma, COPD (emphysema and chronic bronchitis) and depression.

\[4\] Prior authorization (PA) required. When using out-of-network providers, benefits for medically necessary services will be reduced by half if PA is required but not obtained, subject to the maximum allowable charge. If services are not medically necessary, no benefits will be provided.

\[5\] Deductible DOES NOT apply.
## CDHP Plans

### BENEFITS AT A GLANCE

Table 1: CDHP/HSA PLANS - Services in this table **ARE** subject to a deductible with the exception of preventive care and 90-day supply maintenance medications. % = your coinsurance percentage;

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>CDHP/HSA State and Higher Education</th>
<th>LOCAL CDHP/HSA Local Education &amp; Local Government</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-baby, well-child visits as recommended</td>
<td>No Charge</td>
<td>40%</td>
</tr>
<tr>
<td>Adult annual physical exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual well-woman exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunizations as recommended</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual hearing and non-refractive vision screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screenings including Pap smears, labs, nutritional guidance, tobacco cessation counseling and other services as recommended</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Outpatient Services | | |
|---------------------| | |
| **Primary Care Office Visit** | | |
| Family practice, general practice, internal medicine, OB/GYN and pediatrics | 20% | 40% | 30% | 50% |
| Nurse practitioners, physician assistants and nurse midwives (licensed health care facility only) working under the supervision of a primary care provider | | | | |
| Including surgery in office setting and initial maternity visit | | | | |

| | | | | |
| **Specialist Office Visit** | | |
| Including surgery in office setting | 20% | 40% | 30% | 50% |
| Nurse practitioners, physician assistants and nurse midwives (licensed health care facility only) working under the supervision of a specialist | | | | |

| | | | | |
| **Behavioral Health and Substance Use** (including virtual visits) | 20% | 40% | 30% | 50% |
| Telehealth (approved carrier programs only) | 20% | N/A | 30% | N/A |
| Allergy Injection Without Office Visit | 20% | 40% | 30% | 50% |
| Chiropractic (limit of 50 visits per year) | 20% | 40% | 30% | 50% |
| Convenience Clinic | 20% | 40% | 30% | 50% |
| Urgent Care Facility | 20% | 40% | 30% | 50% |

| Emergency Room Visit | 20% | 40% | 30% | 50% |

### Pharmacy

<table>
<thead>
<tr>
<th><strong>30-Day Supply</strong> (generic</th>
<th>preferred brand</th>
<th>non-preferred)</th>
<th>20%</th>
<th>40% plus amount exceeding MAC</th>
<th>30%</th>
<th>50% plus amount exceeding MAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>90-Day Supply</td>
<td>generic</td>
<td>preferred brand</td>
<td>non-preferred</td>
<td>20%</td>
<td>N/A – no network</td>
<td>30%</td>
</tr>
<tr>
<td>90-day network pharmacy or mail order</td>
<td>20%</td>
<td>N/A – no network</td>
<td>30%</td>
<td>N/A – no network</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Certain maintenance medications from 90-day network pharmacy or mail order</td>
<td>10% without first having to meet deductible</td>
<td>N/A – no network</td>
<td>20% without first having to meet deductible</td>
<td>N/A – no network</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **Specialty Medications** (30-day supply from a specialty network pharmacy) | 20% | N/A – no network | 30% | N/A – no network |
### Table 2: CDHP/HSA PLANS

Services in this table are subject to a deductible with the exception of in-network preventive care. 

% = your coinsurance percentage.

<table>
<thead>
<tr>
<th>COVERED SERVICES</th>
<th>CDHP/HSA State and Higher Education</th>
<th>CDHP/HSA Local Education &amp; Local Government</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care – Outpatient Facilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screenings including colonoscopy, mammogram, colorectal, bone density scans and other services as recommended</td>
<td>No Charge</td>
<td>40%</td>
</tr>
<tr>
<td>Other Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital/Facility Services[^4]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient care, outpatient surgery</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>Inpatient behavioral health/substance use[^2]</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>Maternity (Global billing for labor and delivery and routine services beyond initial office visit)</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>Home Care[^4] (Home health, home infusion therapy)</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>Rehabilitation and Therapy Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient and skilled nursing facility[^6]; outpatient</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>X-Ray, Lab and Diagnostics (not including advanced X-rays, scans and imaging[^3])</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>Advanced X-Ray, Scans and Imaging (including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies[^4])</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>All Reading, Interpretation and Results[^4]</td>
<td>20%</td>
<td>30%</td>
</tr>
<tr>
<td>Ambulance (air and ground)</td>
<td>20%</td>
<td>30%</td>
</tr>
<tr>
<td>Equipment and Supplies[^4]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment and external prosthetics</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>Other supplies (i.e. ostomy, bandages, dressings)</td>
<td>20%</td>
<td>40%</td>
</tr>
</tbody>
</table>

#### Also Covered

- Certain dental benefits, hospice care and out-of-country charges – See separate sections in this handbook for details

#### Deductible

<table>
<thead>
<tr>
<th>Coverage</th>
<th>CDHP/HSA State and Higher Education</th>
<th>CDHP/HSA Local Education &amp; Local Government</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$1,500</td>
<td>$3,000</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$3,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$3,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>Employee + Spouse + Child(ren)</td>
<td>$3,000</td>
<td>$6,000</td>
</tr>
</tbody>
</table>

#### Out of Pocket Maximum

<table>
<thead>
<tr>
<th>Coverage</th>
<th>CDHP/HSA State and Higher Education</th>
<th>CDHP/HSA Local Education &amp; Local Government</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$2,500</td>
<td>$4,500</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$5,000</td>
<td>$9,000</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$5,000</td>
<td>$9,000</td>
</tr>
<tr>
<td>Employee + Spouse + Child(ren)</td>
<td>$5,000</td>
<td>$9,000</td>
</tr>
</tbody>
</table>

#### CDHP Health Savings Account (HSA) Contribution

- State contribution made to HSA for individuals enrolled in the CDHP/HSA – State and Higher Education only: $250 for employee only; $500 for all other coverage levels
- N/A

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 (MAC) will not be counted. 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.

[^1]: Subject to maximum allowable charge (MAC). The MAC is the most a plan will pay for a covered service. For non-emergent care from an out-of-network provider who charges more than the MAC, you will pay the copay or coinsurance PLUS the difference between MAC and actual charge.

[^2]: The following behavioral health services are treated as “inpatient” for the purpose of determining member cost-sharing: residential treatment, partial hospitalization/day treatment programs and intensive outpatient therapy. In addition to services treated as “inpatient” prior authorization (PA) is required for certain outpatient services, such as psychological testing, transcranial magnetic stimulation, electro-convulsive treatment, extended outpatient treatment visits beyond 45-50 minutes in duration with or without medication management, and Applied Behavior Analysis.

[^3]: Applies to certain antihypertensives for coronary artery disease (CAD) and congestive heart failure (CHF); oral diabetic medications, insulin and diabetic supplies; statins; medications for asthma, COPD (emphysema and chronic bronchitis) and depression.

[^4]: Prior authorization (PA) required. When using out-of-network providers, benefits for medically necessary services will be reduced by half if PA is required but not obtained, subject to the maximum allowable charge.

[^5]: If services are not medically necessary, no benefits will be provided.
Engaging In Your Health Care

**BlueCross Blue Distinction**

When you or your family need specialty care, you want the best available. Blue Distinction Centers for Specialty Care® helps you find high quality options. Blue Distinction Centers® and Blue Distinction Centers+® have a proven history of delivering exceptional care and results.

<table>
<thead>
<tr>
<th>Quality Care</th>
<th>Blue Distinction Centers</th>
<th>Blue Distinction Centers+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment expertise</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Better overall patient results</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>More affordable care</td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

To find out if a Blue Distinction hospital or health care facility is in your network, contact us at 1-800-558-6213. You can also visit www.bcbs.com/blue-distinction-specialty-care for more information.

* Additional in-network bariatric facilities are available to State Group Insurance Plan members beyond those listed on this site

** Fertility coverage is limited in the State Group Insurance Plan. Check your coverage policy prior to seeking care.

**Quality and Safety in Health Care**

Think about the last time you purchased a car or a major appliance. Did you do your homework? Did you compare features, warranties, costs? Now think about the last time you or a family member went to the hospital or had a medical procedure or service. You probably didn’t even know you might have a choice. And it’s unlikely that you compared services or quality of your health care.

**Quality and safety vary widely in health care.** These resources can help you and your family find the best place to receive high quality care. They also offer suggestions about questions to ask your doctor and how to talk with your doctor about choosing what health care you need and which medical tests and treatments you may not need.

**Know Your Health** – A campaign by ParTNers for Health to educate members on how to engage in their health care and to empower you to become a smarter health care consumer. Includes resources to help you and your family talk with your doctors about choosing the health care you need, what you may not need and the best place to receive care. www.tn.gov/partnersforhealth/know-your-health.html

- **Leapfrog Hospital Safety Grade** – A consumer-friendly letter grade rating of more than 2,600 hospitals on their records of patient safety. www.hospitalsafetygrade.org

**Spring 2018 Tennessee Hospital Safety Grades**

- **Leapfrog Hospital Survey Results** – Program for public reporting of hospital safety, quality and resource use. www.leapfroggroup.org/compare-hospitals

- **Choosing Wisely** – Promoting conversations between patients and clinicians. An initiative of the American Board of Internal Medicine Foundation that seeks to advance a national dialogue on avoiding unnecessary medical tests, treatments and procedures. www.choosingwisely.org

12
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 colonoscopy or a mammogram, it is very important that you talk to your health care provider about the type of service you will have. There is no charge for in-network preventive services. However, you will be charged for services scheduled for diagnostic purposes or billed as anything other than preventive care.

Claims for prescription drugs obtained from a retail pharmacy or mail order are processed under pharmacy benefits. Behavioral health claims are processed under behavioral health benefits.

If you have questions about pharmacy or behavioral health expenses, see publications specific to those programs at the ParTNers for Health website at https://www.tn.gov/partnersforhealth.html. Phone numbers are also provided under the “Important Contact Information” section of this handbook.
Charges for the following services and supplies are eligible covered expenses under the State of Tennessee Group Insurance Program.

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 (cdc.gov/vaccines).

2. Well-child visits to physicians including checkups and immunizations. Annual checkups for ages 6-17 and immunizations as recommended by the Centers for Disease Control and Prevention (cdc.gov/vaccines).

3. 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 three months, unless medically necessary
   - Screening and counseling for interpersonal and domestic violence (annually)

4. 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.

5. Hearing impairment screening and testing (annually per plan year) 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.

6. 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 for adults (annually per plan year) 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.

7. 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.
   - Adult annual physical exam – age 18 and over
   - 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.
   - CBC with differential, urinalysis, glucose monitoring – age 40 and over or earlier based on doctor’s recommendations and medical necessity
   - Cholesterol screening
   - Colorectal screenings. Screening for colorectal cancer (CRC) in adults using fecal occult blood testing, sigmoidoscopy, or colonoscopy
   - Depression screening for adolescents and adults.
• Healthy diet counseling for medical conditions other than diabetes, limited to three visits per plan year.

• Mammogram screenings.

• Over-the-counter, generic forms of aspirin with a maximum quantity of up to 100 every 90 days. Males 45 and older - 75mg, 81mg, 162mg, and 325mg covered. Females 45 and older - 75mg, 162mg and 325mg covered. In addition, Females age 12 and older - at risk for pre-eclampsia - 81mg covered. A prescription is required.

• 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 preventive screening lab charges and associated office visits for Pap smears covered per plan year beginning with age 18. Testing prior to the age of 18 will also be covered if recommended by a physician and determined to be medically necessary; 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.

• 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.

8. Office visits to a physician or a specialist due to an injury or illness, or for preventive services.

9. Charges for diagnostic tests, laboratory tests and X-ray services in addition to office visit charges.

10. Charges for the taking and/or the reading of an x-ray, CAT scan, MRI, PET or laboratory procedure, including physician charges and hospital charges. Covered persons or their provider must obtain prior authorization prior to incurring charges for use of advanced imaging technology.

11. Medically necessary ground and air ambulance services to and from the nearest general hospital or specialty hospital which is equipped to furnish treatment.

12. Hospital room and board and general nursing care and ancillary services for the type of care provided if preauthorized.

13. Services and supplies furnished to the eligible covered persons and required for treatment and the professional medical visits rendered by a physician for the usual professional services (admission, discharge and daily visits) rendered to a bed patient in a hospital for treatment of an injury or illness, including consultations with a physician requested by the covered person’s physician.


15. Charges by a physician, anesthesiologist or nurse anesthetist for anesthesia and its administration. This shall include acupuncture performed by a physician or a registered nurse as an anesthetic in connection with a surgical procedure.

16. Private-duty or special nursing charges (including intensive nursing care) for medically necessary and/or clinically necessary treatment and services rendered by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), who is not an immediate relative, if prescribed by the attending physician.

17. Sitter. A sitter who is not a relative (i.e. spouse, parent, child, brother or sister by blood, marriage or adoption or member of the household) of the covered person may be used in those situations where the covered person is confined to a hospital as a bed patient and certification is made by a physician that an R.N. or L.P.N. is needed and neither (R.N. or L.P.N.) is available.

18. Certain organ and bone marrow transplant medical expenses and services only at Medicare-approved facilities (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.

19. Charges for chemotherapy and radiation therapy when medically necessary as determined by the claims administrator. Covered persons or their provider must obtain prior authorization and coverage is subject to utilization management review.
20. 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.

21. Reconstructive breast surgery following a covered mastectomy (but not a lumpectomy), as well as surgery to the non-diseased breast to establish symmetry; medically necessary prostheses and mastectomy bras.

22. Maternity Benefits. The plan provides coverage for pregnancy, childbirth or related medical conditions, unless the covered person is acting as a surrogate mother (carrying a fetus to term for another woman) in which case no benefits will be payable.
- Pregnancy Care. Normal maternity and complications of pregnancy will be covered without being subject to any special pregnancy limitations, exclusions, extensions and benefit restrictions that might be included in this plan.
- Newborn Care. Coverage for a newborn child shall be provided to covered employees who have elected family coverage. Covered expenses of a newborn child shall include:
  - Any charges directly related to the treatment of any medical condition of a newborn child;
  - Any charges by a physician for daily visits to a newborn baby in the hospital when the baby’s diagnosis does not require treatment;
  - Any charges directly related to a circumcision performed by a physician; and
  - The newborn child’s usual and ordinary nursery and pediatric care at birth are covered.

23. 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.

24. Preauthorized surgical weight reduction procedures. 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.

25. Reasonable charges for transportation (reasonable charges include round-trip coach air fare, the state standard mileage rate or actual fuel expenses for round-trip usage of a personal car or other mode of transportation if pre-approved by the claims administrator) to a hospital or between hospitals for medical services that have been authorized by the claims administrator as a unique exception under the plan (excluding any transportation from or to points outside the continental limits of the United States). Benefits will be available for one caregiver to accompany the patient.

26. Therapy. Speech, physical and/or occupational. Preauthorized inpatient therapy benefits and medically necessary outpatient therapy benefits are covered, including habilitative and rehabilitative services as defined in the Affordable Care Act’s Uniform Glossary of Health Coverage and Medical terms. Specific to rehabilitation therapy, coverage is available for conditions resulting from an illness or injury, or when prescribed immediately following surgery related to the condition. No therapy services will be covered if the claims administrator determines services are not medically necessary or if the covered person is no longer progressing toward therapy goals.
- Cardiac rehabilitation services will be covered when determined to be medically necessary by the claims administrator.
- Outpatient pulmonary rehabilitation will be covered for certain conditions when determined to be medically necessary by the claims administrator.

New! Medical Benefit Improvements for in-network, outpatient services:
- Physical, Occupational and Speech Therapies – PPO members no longer have to meet a deductible for in-network, outpatient physical, occupational and speech therapies. You only pay coinsurance.
- Cardiac Rehab – PPO members pay no deductible or coinsurance for in-network, outpatient services; CDHP/HSA members pay deductible, but no coinsurance.
27. 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.

28. 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. Covered persons or their provider must obtain prior authorization.

29. Cochlear Implantation. The plan provides coverage for cochlear implantation using FDA-approved cochlear implants determined to be medically necessary by the claims administrator. Covered persons or their provider must obtain prior authorization.

30. Bone anchored hearing devices. Covered persons or their provider must obtain prior authorization.

31. The first contact lenses or glasses (excluding tinting and scratch resistant coating) purchased after cataract surgery (including examination charge and refraction).

32. 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.

33. Artificial eyes - the initial purchase, and subsequent purchases due to physical growth for a covered dependent through age 18, or as a result of injury or illness.

34. Continuous passive motion machine for knee replacement surgery or anterior cruciate ligament repair for up to 28 days after surgery.

35. 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.

36. 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.

37. 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-ulcerative 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.

38. “Space” or molded shoes, limited to once per lifetime, and only when used as a substitute device due to all, or a substantial part, of the foot being absent.

39. 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 also available through the ParTNers for Health wellness program.

40. Charges for treatment received by a licensed doctor of podiatric medicine or for treatment by a licensed doctor of chiropractic provided treatment was within the scope of his/her license, unless listed as an exclusion.
41. Routine foot care for diabetics including toenail clipping and treatment for corns and calluses.

42. Nutritional Treatment of Inborn Errors of Metabolism. The plan will cover special nutritional needs resulting from genetic disorders of the digestive cycle (such as phenylketonuria [PKU], maple syrup urine disease, homocystinuria, methylmalonic acidemia and others that result in errors within amino acid metabolism) when determined to be medically necessary by the claims administrator. Coverage includes licensed professional medical services under the supervision of a physician and those special dietary formulas that are medically necessary for therapeutic treatment.

43. Enteral Nutrition (EN) and Total Parenteral Nutrition (TPN). The plan will cover medically necessary nutrition prescribed by a physician and administered either through a feeding tube or central venous catheter when determined to be medically necessary by the claims administrator.

44. 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.

45. Skilled Nursing Facility Care. Charges for room, board and general nursing care, provided:
   - A physician recommends skilled nursing facility care for rehabilitation or recovery of a covered illness or injury;
   - The covered person is under the continuous care of a physician during the entire period of facility care;
   - The facility care is required for other than custodial services; and
   - Services were preauthorized by the claims administrator.

Eligible charges for facility room, board and general nursing care shall only include:
   - Charges not to exceed the charge for its greatest number of semi-private rooms; and
   - Charges up to and including the 100th day of skilled nursing facility care during any plan year.

46. 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.

47. Covered dental expenses. Orthodontic treatment for correction of facial hemiatrophy or congenital birth defect which impairs bodily function, 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. 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.

48. Eligible medical expenses for treatment of Autism Spectrum Disorders as specified in TCA 56-7-2367.

49. Routine patient costs related to clinical trials as defined by TCA 56-7-2365.

50. Charges for laser procedures, other than those specifically excluded.

51. Pharmacy benefits such as covered drugs and medicines, including certain preferred anti-obesity medications (as determined by the pharmacy benefits manager), subject to prior authorization. FDA approved medications which are prescribed for accepted off-label indications; limited prescription agents and over-the-counter nicotine replacement therapies; medically necessary insulin and diabetic supplies. Pharmacy benefits are not administered by BlueCross BlueShield of Tennessee. See the pharmacy section in this handbook for more details about pharmacy benefits.
Excluded Services and Procedures

Charges for the following services and supplies are excluded under the State of Tennessee Group Insurance Program unless otherwise specified as covered expenses in this handbook or the Plan Document or if coverage is required by applicable state or federal law.

1. Services rendered prior to the effective date of coverage.
2. Services incurred after plan coverage is terminated.
3. Services or supplies for which there is no charge to the covered person, or for which the covered person would not have been charged if not covered by the plan.
4. Services provided by a participant’s immediate family member, whether by blood, marriage, or adoption.
5. Services not ordered or furnished by an eligible provider, including but not limited to, services given by a pastoral counselor.
6. Ecological or environmental medicine, diagnosis and/or treatment.
7. Charges in excess of the maximum allowable charge or charges determined not to be medically necessary or clinically necessary.
8. Medical or surgical treatments, procedures, facilities, equipment, drugs, or supplies determined by the claims administrator to be experimental, investigational, or unproven. (Members are held harmless for charges or services from network providers unless they have signed a waiver accepting responsibility for the cost.)
9. Treatment in connection with any injury or illness which arose out of or in the course of employment; on the job injuries and illnesses; charges that would be considered a covered injury paid under workers’ compensation, regardless of the presence or absence of workers’ compensation coverage.
10. Examinations and services provided for employment, licensing, insurance, school, camp, sports, adoption or other non-medically necessary and/or clinically necessary purposes; related expenses for reports, including report presentation and preparation; vocational therapy, vocational rehabilitation, education therapy, and recreational therapy
11. Sensitivity training, educational training therapy or treatment for an education requirement.

12. Court or employer ordered or required examinations or care, or care in lieu of legal involvement or incarceration, unless otherwise considered medically necessary and/or clinically necessary by the claims administrator.

13. Treatment of an injury or illness due to declared or undeclared war.

14. Comfort or convenience items (e.g. television, telephone, radio, air conditioner, beauty shop and barber services, guest meals and guest beds, bathroom chairs, stools, and tub handrails).

15. Humidifiers, dehumidifiers, air filters, whirlpools, heating pads, sun or heat lamps, air conditioners, air purifiers and exercise devices.

16. Arch supports, corn plaster (pads, etc.), foot padding (adhesive moleskin, etc.) orthotic or orthopedic shoes and other foot orthoses (including inner soles or inserts), 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.

17. Garter belts and elastic stockings, except Jobst or similar quality support hose, when medically necessary as determined by the claims administrator.

18. Hearing aids for adults 18 years and older, including examinations and fittings.

19. Midwife services outside a licensed health care facility.

20. Nonsurgical service for weight control or reduction, including prescription medication and weight loss programs, fitness clubs and programs. This exclusion does not apply to certain preferred anti-obesity medications, healthy diet counseling as described in the covered expenses section of this handbook, ParTNers for Health sponsored programs, or participation in an integrated clinical program as part of the bariatric surgery benefit.

21. Organ transplants involving artificial organs and nonhuman organ transplants, as well as any services or supplies in connection with experimental or investigational treatment, drugs, or procedures, unless determined to be medically necessary by the claims administrator.

22. Radial keratotomy, LASIK, or other procedures to correct refractive errors; eyeglasses, sunglasses, or contacts including examinations and fitting charges.

23. Surgery or treatment for, or related to, psychogenic sexual dysfunction or transformation other than psychological treatment or counseling.

24. Services or supplies in connection with fertility preservation, artificial insemination, in-vitro fertilization, or any procedure intended to create a pregnancy.

25. Wigs.

26. Ear or body piercing.

27. Custodial care, unapproved sitters, day and evening care centers (primarily for rest or for the elderly), or diapers.

28. Programs considered primarily educational and materials such as books or tapes.

29. Extraneous fees such as postage, shipping or mailing fees, service tax, stat charges, or collection and handling fees.

30. Drugs and supplies which can be obtained without a prescription, including nutritional supplements, vitamins, and oral nutritional formulas for infants and adults which can be obtained at retail or over-the-counter without a written prescription. Nutritional treatment of inborn errors of metabolism, Enteral Nutrition (EN), and Total Parenteral Nutrition (TPN) are not excluded.

31. Hotel charges unless pre-approved through the organ transplant program.

32. Cosmetic surgery and related expenses including, but not limited to, scar revision, rhinoplasty, prosthetic penile implants, saline injection of varicose veins, and reconstructive surgery where no significant anatomic functional impairment exits.

33. 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.

34. Reversal of sterilization procedures.

35. Charges incurred outside the United States unless traveling for business or pleasure.
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 or 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.

Should you need assistance locating and scheduling an appointment with a network provider who is accepting new patients or has reasonable availability (i.e. urgent visit in 24 hours, wellness visit in two months, routine medical visit in 14 days, specialist visit in 30 days or routine mental health visit in four days), you can call the claims administrator (either BlueCross or Optum).

Telehealth

Telehealth services allow you to receive care through virtual visits. You can contact a doctor for minor illnesses such as cold or flu, infections, fever and more. Schedule a visit for you or your covered dependents for anywhere, at any time.

Pre-registration is very important so you can access telehealth services when you need them. You must go through PhysicianNow to use the state-sponsored telehealth program for medical services.
For PPO plans, the cost is only $15 per telehealth visit. For CDHP/HSA plans, you pay the negotiated rate until you reach your deductible, then the primary care office coinsurance applies. The cost listed above does not apply to telemedicine services received from a different program or provider. There is no coverage for telephone consultations, unless you use PhysicianNow through BlueCross BlueShield. Call member service if you have any questions or need assistance with the registration process.

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 cost 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.

Hospice Benefits
Your plan covers approved hospice programs designed to provide terminally ill patients with more dignified, comfortable and less costly care during the six months before death. Prior authorization is required.

Dental Treatment
Your medical plan covers certain limited benefits for dental treatment - extraction of impacted wisdom teeth, excision of solid-based oral tumors, accidental injury to sound natural teeth (other than by eating or chewing). The chart below details your coinsurance amount, depending on the plan you’re enrolled in. All benefits are after deductible.

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<thead>
<tr>
<th>Plan</th>
<th>oral surgeons</th>
<th>Non-Contracted Providers (i.e., dentists, orthodontists)</th>
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<td>In-network</td>
<td>Out-of-Network</td>
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<td>Premier PPO</td>
<td>10%</td>
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<td>Standard PPO</td>
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<td>Limited PPO</td>
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<td>CDHP/HSA</td>
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<td>Local CDHP/HSA</td>
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Plan Deductible
An annual deductible is the amount you pay each year before the plan pays for services that require coinsurance.

For PPO plans, members in a family plan DO have an individual deductible equal to the “employee only” amount.

For CDHP plan, members in a family plan DO NOT have an individual deductible limit. Each family member will contribute to the overall family deductible which must be met before the plan begins to pay for any family member’s claims subject to a deductible.

See the “Benefits At a Glance” benefit grids in this handbook for deductible amounts.

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.

**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.

**For PPO plans,** members in a family plan **DO** have an individual out-of-pocket maximum amount equal to the “employee only” amount.

**For the CDHP/HSA plan,** state and higher education members in a family plan **DO NOT** have an individual out-of-pocket limit. Each family member will contribute to the overall family out-of-pocket amount which must be met before the plan covers the family’s eligible in-network expenses at 100% for the remainder of the plan year.

**For the Local CDHP/HSA plan,** local education and local government members in a family plan **DO** have an individual out-of-pocket limit FOR IN-NETWORK EXPENSES ONLY. No one family member will pay more than the $7,900. Once a family member has eligible in-network expenses out-of-pocket costs totaling $7,900, the plan will cover that family member’s eligible in-network expenses at 100 percent for the remainder of the plan year.

See the “Benefits At a Glance” benefit grids in this handbook for out-of-pocket limits.

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 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. 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 BlueCross BlueShield 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 cost is paid by the member.

**Convenient Care and Urgent Care**

Members sometimes have a need for medical care during evenings or on weekends. “Convenient Care” and “Urgent Care” is care that is important, but does not result from a life-threatening condition. You can conduct a provider search online or refer to a provider directory to find network facilities.

Convenient care clinics can help with common conditions like burns and sprains, sinus infections, sore throats, skin rashes and upset stomachs. These type clinics are often located in grocery or drug stores. Your cost for a convenient care clinic visit is the same as a primary care visit.

Urgent care centers treat more serious illnesses, like broken bones or deep cuts, that may require X-rays or more complicated lab tests. They are often near a hospital but can also be free standing. Your cost for an urgent care center visit is the same as a specialist visit. Urgent care health problems are usually marked
by rapid onset of persistent or unusual discomfort associated with an illness. If you need urgent care, seek treatment at an urgent care center or 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.

Emergency Care
If you have a medical emergency, seek treatment at the nearest medical facility. Contact your doctor or our member services 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 your portion of the emergency room cost 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 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 (PA)**

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. PA 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 (certain equipment)
- Same-day surgery procedures, including procedures at an ambulatory surgical center (does not apply to screening colonoscopy)
- Chemotherapy and radiation therapies

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 PA 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 that are not medically necessary or for services received from network providers who fail to obtain PA.

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

**Advanced Radiological Imaging**

BlueCross 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 Tomography (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. Some equipment requires prior authorization (PA). Generally, authorization only applies to more expensive items. Providers should request any necessary authorization in advance of providing equipment to you. You can also contact BlueCross to see if the equipment you need requires PA and if any necessary PA has been approved. 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.
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/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 that 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 must be received before any further claims processing can take place. You may also update this information online at bcbst.com/otherinsurance, or you can call us at 1-800-200-3704.

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.

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 a member’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 or for actual fuel expenses, if appropriate.

When unique care exceptions are granted, a timeframe 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 services 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 use 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 bcbs.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 800-558-6213 before leaving the U.S.
3. If you need emergency medical care, go to the nearest hospital. Call the BlueCross BlueShield Global CoreSM Service Center at 800-810 BLUE (2583) or call collect at 804-673-1177 if you are admitted.
4. If you need non-emergency medical care, you must call the BCBS Global Core Service Center. The Service Center will facilitate hospitalization at a BCBS Global Core hospital or make an appointment with a doctor. It is important that you call the BCBS Global Core 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.

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<tr>
<th>Out-of-Country Benefits</th>
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<td>non-emergency and non-urgent care</td>
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Member Discount Program

The goal of our members-only discount program is simple – to help make living a healthy lifestyle more affordable. You can save on a wide range of health and wellness-related products and services with these discounts. Visit bcbs.com to find out how you can save on offers for:

- Fitness
- Personal care
- Healthy eating
- Lifestyle
- Wellness

Check often for new offers or opt-in to get offers sent to your inbox.

Members must pay the whole cost of all services they get through the program. The terms and conditions of the member’s health plan do not apply to these services.
Pharmacy Benefits

Pharmacy benefits are administered by CVS/caremark and not BlueCross BlueShield of Tennessee. Please call 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 member cost. 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.

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

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 or coinsurance.

NEW – Medication Assisted Treatment (MAT)

Medication assisted treatment (MAT) combines behavioral therapy and medications to treat substance use disorders. Members do not have to pay for specific medications used to treat opioid dependency.

Maintenance Drugs

When you fill a prescription for chronic maintenance medications, you can save money by paying a lower copay or coinsurance when you have your doctor write a prescription for a 90-day supply and you fill it through either mail order or from a participating Retail-90 pharmacy. A list of participating Retail-90 pharmacies is located at info.caremark.com/stateoftn.

Maintenance drugs include certain medications for high blood pressure, high cholesterol, coronary artery disease (CAD), congestive heart failure (CHF), depression, asthma/chronic obstructive pulmonary disease (COPD), and diabetes (oral medications, insulins, needles, test strips and lancets).

NEW – Med Sync for Maintenance Drugs

Maintenance drugs are described above. You can request that refills of your maintenance drugs be synchronized so that you can have them all filled on the same day. If you’re enrolled in a PPO, you will pay pro-rated copays for any maintenance drugs being synchronized. Persons enrolled in a CDHP will pay the actual drug cost. If you want to sync your maintenance drugs, you will need to work with your retail pharmacy or mail order pharmacy to coordinate synchronization of your refills.

Compound Drugs

Any and all compound drugs (as determined by the pharmacy benefits manager) must be processed electronically. Paper claims will not be reimbursed and will be denied. In addition, many compound drugs require prior authorization by the pharmacy benefits manager before claims processing and determination on payment will occur.

Statin Drugs

Eligible members may receive certain low-dose statins in-network at zero cost share. These drugs are primarily used to treat high cholesterol. No high dose or brand statins are included.
Weight Management

Some obesity medications are available for members who meet certain requirements. This gives members a less costly, non-surgical option for losing weight. Go to the Caremark website at info.caremark.com/stateoftn to look for covered medications. They are found under “Antiobesity” on the Preferred Drug List (PDL).

Tobacco Cessation Products

Members who want to stop using tobacco products can get free tobacco quit aids. Chantix, Bupropion (Generic Zyban) over-the-counter generic nicotine replacement products (including gum, patches and lozenges) and Nicotrol oral and nasal inhalers are FREE under the pharmacy benefit. Members may receive up to two, 12-week courses of treatment per calendar year (up to 168 days of treatment) with no lifetime maximum. A licensed clinician is required to write a prescription to get any tobacco cessation products at no cost, including over-the-counter aids. Simply present your prescription and your caremark card at the pharmacy counter (not at the check-out registers) to fill at $0 copay. The plan only covers generic over-the-counter tobacco cessation products (not brand names).

Copay Installment Program

Members can spread the cost of 90-day mail order prescriptions over a three-month period – at no additional cost. You may enroll online at info.caremark.com/stateoftn, register and log in, or by calling CVS/ caremark customer care at 877.522.8679. This benefit is only for 90-day mail order prescriptions provided by CVS/caremark mail order. This does not apply to specialty medications.

Flu and Pneumonia Vaccines

Each year, members can get free flu and pneumonia vaccines (if eligible) through certain pharmacies or at a participating doctor’s office. Contact CVS/caremark (pharmacy benefits) or BCBS (medical benefits) for more information or go to tn.gov/partnersforhealth and click on Pharmacy.

Here4TN Behavioral Health, Substance Use and Employee Assistance Program

You and your dependents enrolled in health coverage are eligible for behavioral health and substance use benefits, which are administered by Optum Health. Services generally include the following:

- Outpatient assessment and treatment
- Virtual Visits - visits with a provider through private, secure video conferencing
- 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 Optum.

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, electro-convulsive treatment, Applied Behavior Analysis, extended outpatient treatment visits beyond 45-50 minutes in duration with or without medication management and transcranial magnetic stimulation.

Optum can be reached toll-free at 855-Here4TN (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, your cost will be higher. You are also subject to balance billing by the out-of-network provider, meaning that you will pay the difference between the maximum allowable charge and the actual charge. Additionally you are at risk of having inpatient benefits totally denied.
You also have access to an Employee Assistance Program (EAP) that provides up to five counseling sessions per situation, per year at no cost to you. EAP is now available through virtual visits as well. Go to Here4TN.com for more information. 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 in to Here4TN.com or calling 855-Here4TN (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.

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

ParTNers for Health Wellness Program

The ParTNers for Health wellness program is voluntary and members are not required to complete any wellness program activities. ActiveHealth Management, the wellness vendor, will send more information directly to members about the programs, tools and resources that are available in 2019. Go to http://goactivehealth.com/wellnessstn for updates.

- State and higher education members and enrolled spouses - regardless of the health plan you choose, you can earn money by completing certain wellness activities. The money will be deposited into the head of contract’s paycheck. Members choose activities from an approved list. Each activity will have a dollar value and you can earn up to $250 each. That is $500 for the employee and spouse.
- Local education and local government employees, retirees, COBRA participants and enrolled spouses will have disease management for members with asthma, diabetes, coronary artery disease (CAD), congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD) to better manage their chronic condition. There is also a Diabetes Prevention Program (DPP) for those who are pre-diabetic and qualify for the program. More information about who is eligible and how to access these two programs will be shared in 2019.
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 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 our 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 to us. 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 Use Appeals

Contact Optum at 1-855-437-3486 for EAP, behavioral health and substance use 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 timeframes. 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).

The appeals/grievance form can be found on the BlueCross BlueShield of Tennessee Member Home Page at bcbst.com/members/tn_state. Members will have 180 days to initiate an internal appeal following notice of an adverse determination. Where an internal appeal decision is unfavorable and the appeal qualifies for external review, BlueCross BlueShield will advise the member of their right to initiate an external appeal within four months of notice of the internal decision.

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 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.

Notification of decisions will be made within the following time frames and all decision notices shall advise of any further appeal options:

- No later than 72 hours after the receipt of the appeal for urgently needed services
- 30 days for denials of non-urgent care not yet received
- 60 days for denials of services already 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 use the BlueCard® PPO program when getting care. 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  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  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  Am I covered for hospital-based providers?
A  In the event of covered expenses incurred with hospital-based providers, reimbursement will be made at the network level of benefits. The covered person will not be responsible for any expenses which exceed the maximum allowable charge for any providers of service that are hospital-based providers. Hospital-based providers include, but are not limited to, emergency room physicians, anesthesiologists, radiologists, and pathologists.

Q  What if my doctor is out of the office?
A  Doctors “cover” for each other on a rotating schedule. This means you may not always be able to talk with your doctor. The nurse or doctor on call will be able to help you.

You can also use telehealth service, which allows you to receive care through virtual visits. **For PPO plans**, the cost is only $15 per telehealth visit. **For CDHP plans**, you pay the negotiated rate until you reach your deductible, then the primary care office visit coinsurance applies.

Q  What if I must reach my physician after regular office hours?
A  Most offices have an answering service. 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 ask for some identifying information and will need a general description of your urgent medical need.

Another option is telehealth, which allows you to receive care through virtual visits. You can contact a doctor for minor illnesses such as cold or flu, infections, fever and more. Schedule a visit for you or your covered dependents for anywhere, at any time. **For PPO plans**, the cost is only $15 per telehealth visit. **For CDHP plans**, you pay the negotiated rate until you reach your deductible, then the primary care office visit coinsurance applies.

Pre-registration is very important so you can access telehealth services when you need them.

Call member services if you have any questions or need help with the registration process.
BlueCross BlueShield of Tennessee (BlueCross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BlueCross does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. BlueCross does not discriminate on the basis of race, color, national origin, age, disability or sex. BlueCross does not discriminate on the basis of race, color, national origin, age, disability or sex.

BlueCross:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified interpreters and (2) written information in other formats, such as large print, audio and accessible electronic formats.

- Provides free language services to people whose primary language is not English, such as: (1) qualified interpreters and (2) written information in other languages.

If you need these services, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-558-6213 (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 1-800-558-6213 (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 Compliance Coordinator; 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).


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

**ATENCIÓN**: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-558-6213 (TTY: 1-800-848-0298).

**CHÚ YÊ**: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-558-6213 (TTY: 1-800-848-0298).

**注意**: 如果您使用繁體中文, 您可以免費獲得語言援助服務。 請致電 1-800-558-6213 (TTY:1-800-848-0298)。

**ATENÇÃO**: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-558-6213 (TTY: 1-800-848-0298).

**ATENZIONE**: In caso la lingua parlata sia l’italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-558-6213 (TTY: 1-800-848-0298).

**注意**: 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。 1-800-558-6213 (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. Tumawag sa 1-800-558-6213 (TTY:1-800-848-0298).

**PÅTALOG**: Hvis du taler norsk, er det tilgjengelig gratis språkstøtte. Ring 1-800-558-6213 (TTY:1-800-848-0298).

**PUBLIKATIE**: Indien enkele spraaktaal is, is spraakondersteuning gratis beschikbaar. Neem contact op door het nummer 1-800-558-6213 (TTY:1-800-848-0298) te bellen.

**注意**: 如果您使用简体中文, 您可以免費獲得語言援助服務。 請致電 1-800-558-6213 (TTY:1-800-848-0298)。
Get information when you need it.

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.
- Find an in-network provider.