

STATE | HIGHER EDUCATION | LOCAL EDUCATION | LOCAL GOVERNMENT

State of Tennessee 2021 Member Handbook

PREMIER PPO | STANDARD PPO | LIMITED PPO | CDHP/HSA | LOCAL CDHP/HSA



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Important Reminders

- **Your health coverage is effective Jan. 1, 2021 through Dec. 31, 2021, subject to eligibility.** You won't be able to change plans or networks for 2021. You may be able to make changes allowed by the plan if you have a qualifying event. A provider or hospital leaving a network is not a qualifying event.
- **Benefit grids on pages 12 – 15 outline your responsibility for your cost share of medical expenses.** Your cost share applies even if this plan is your secondary coverage. See the Coordination of Benefits (COB) section on page 31 for more details.
- **Take care when signing medical waivers** or other documents that might make you financially responsible for unpaid charges.
- **See the "If You Have Questions" section on page 8 and make contact as soon as possible.** A delay could cause you to miss important deadlines.

Benefit Highlights

Members have three separate ID cards for medical services, behavioral health/substance use disorder services and pharmacy services. The back of each card has a specific customer service number. Using the correct card and calling the number on that card will improve your customer service experience.

Medical – Call 1-800-558-6213 for more information

- **Acupuncture benefits***

You have coverage for regular acupuncture treatments. The benefit is the same as chiropractic, but with a separate 50-visit limit.

- **Cost savings for approved transplants at certain preferred transplant facilities***

- BCBS Blue Distinction Center of Excellence (COE) Transplant Facilities
- In-Network facilities when there is no BCBS Blue Distinction COE option
- PPO members – no cost; deductible and coinsurance are waived
- CDHP members – no cost after deductible; coinsurance is waived

- **Provider-Administered Specialty Medications Outreach**

Some medications are given to you in an office or outpatient setting for chronic, serious diseases such as hepatitis C and arthritis. Your doctor will take care of approvals and order these medications for you. You may get a call from a pharmacy vendor or your doctor's office to gather more information if you need one of these medications. If you get a call, it's important that you provide what is asked of you. Doing so will allow the order for your medication to be filled without delay. You will pay your usual cost share (copay or deductible and coinsurance) for your medication, and your provider will give it to you. This program will not result in any change to pharmacy benefits administered by CVS Caremark.

- **Temporary cost savings related to Coronavirus – Visit www.tn.gov/partnersforhealth for the latest updates**

- Benefits available until the National Public Health Emergency (NPHE) ends - NPHE end date as of this printing is January 21, 2021. Benefits will be extended if the NPHE date is extended
- No member cost for telehealth visit through carrier-sponsored telehealth programs
- No member cost for all FDA approved COVID-19 diagnostic and antibody testing and in-network outpatient visits associated with these tests
- No member costs for in-network COVID-19 medical treatment

Behavioral Health And Substance Use – Call Optum Health at 1-855-437-3486 for more information

- **Cost savings for facility-based treatment at certain preferred substance use (alcohol/drug) treatment facilities^{*} :**
 - Find preferred Optum providers by calling **855-Here4TN** or visiting **Here4TN.com**
 - PPO members – no cost; deductible and coinsurance are waived
 - CDHP members – no cost after deductible; coinsurance is waived
 - Cost sharing still applies for standard outpatient treatment services

Pharmacy – Call CVS Caremark at 877-522-8679 for more information

- **Cost savings for 90-day supply of certain maintenance medications from 90-day network pharmacy or mail order**
 - 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), depression, **and some osteoporosis medications have been added to the list**
 - PPO and CDHP plan members can receive a 90-day supply of maintenance meds for the equivalent of the cost for two 30-day supplies. For CDHP members, these maintenance tier medications bypass the deductible and you pay the lower, discounted cost immediately

^{*} See “Benefits At A Glance” charts, the “Covered Medical Expenses” and “How The Plan Works” sections in this handbook on pages 12, 17 and 25 respectively for more details. Standard benefits will apply when members elect treatment at non-preferred facilities. Prior authorization is required for inpatient care.

Important Notices

This combined member 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 Preferred Provider Organization (PPO), Standard PPO, Limited PPO, Consumer-Driven Health Plan/Health Savings Account (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.

The ParTNers for Health website (www.tn.gov/partnersforhealth) 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.

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 7.

Need help with a bill? If you receive a bill for medical services that is more than you expected to pay, call BlueCross BlueShield of Tennessee Member Service at **1-800-558-6213**. Ask us to look at your claim and discuss the bill you received from your provider. Have your BlueCross Explanation of Benefits (EOB) and the bill from your provider in front of you so that we can review them together. No worries if you don't have a printed copy of your EOB. You can find it by signing in to your secure and personal account at **bcbst.com/members/tn_state/**

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 **(615) 532-9617**



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 75 years to provide quality, affordable health care. Today, more than 3 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 an in-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 SSM**. Review this information carefully and call if you have any questions.

See your actual Member ID card.

Front

Callouts for Front:

- In-network amounts (copayment or coinsurance) for various health care services:** Points to the "BLUE NETWORK: S" field.
- Your Blue Network[®] letter (S) identifies which network you're enrolled in:** Points to the "BLUE NETWORK: S" field.
- 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

Back

Callouts for Back:

- Prior authorization instructions:** Points to the "BCBST provides administrative Services only and assumes no financial risk for claims." section.
- Member Service phone number:** Points to "Member Service: 1-800-558-6213".
- The number to call if you're outside Tennessee:** Points to "Network Provider Outside Tennessee: 1-800-810-2583 (BLUE)".
- Prior authorization contact information including hospitals, advanced imaging services, etc.:** Points to "Provider Service: Eligibility / ALL Prior Authorizations (call to confirm) and Claims 1-800-924-7141".
- Other important numbers:** Points to "For Pharmacy Benefits*: Call 1-877-522-8679" and "For behavioral health and substance use services* call: 1-855-HERE-4-TN (1-855-437-3486)".

Card Details:

Front: BlueCross BlueShield of Tennessee logo, TENNESSEE STATE GROUP INSURANCE PROGRAM, PARTNERS FOR HEALTH logo, CHRIS B HALL, Member ID STL123456789, Group No. 80860, BLUE NETWORK: S, PPO logo.

Back: BCBST logo, BCBST provides administrative Services only and assumes no financial risk for claims. Providers Submit claims to your local BCBS Plan. Prior authorization required for admissions and certain medical services. Members: Show this card and tell your provider to check for prior authorization to avoid additional costs. Check your benefit materials for details. Possession of this card does not guarantee eligibility for benefits. BCBST Claims Service Center 1 Cameron Hill Circle Suite 0002 Chattanooga, TN 37402-0002. bcbst.com Member Service: 1-800-558-6213 Network Provider Outside Tennessee: 1-800-810-2583 (BLUE) Provider Service: Eligibility / ALL Prior Authorizations (call to confirm) and Claims 1-800-924-7141 For Pharmacy Benefits*: Call 1-877-522-8679 For behavioral health and substance use services* call: 1-855-HERE-4-TN (1-855-437-3486) * Group contracts separately for these services 868 (09/18)

Where's My BCBS Card?

- The cards you used in 2020 are still valid; new cards will only be mailed to you if you have added new dependents, changed to a new plan OR if you are a new BCBS customer
- Print temporary cards and request replacement cards at www.bcbst.com/log-in/member
- Access your card on the MyBlueTN Mobile App[®] secure app

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 uses the benefit structure approved by the Insurance Committee that governs the plan. When claims are paid under this plan, they are paid from a fund made up of your premiums and the employer contributions. BlueCross BlueShield of Tennessee is contracted by the state to process claims, establish and maintain 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.

If You Have Questions:

- about eligibility or enrollment (e.g., becoming insured, adding dependents, when your coverage starts, transferring between plans, ending coverage) - contact your agency benefits coordinator. They will work with Benefits Administration to help you.
- about health coverage (e.g., prior authorization, claims processing or payment, bills, benefit statements or letters from your health care provider or BlueCross BlueShield) - contact BlueCross BlueShield member service at **1-800-558-6213**. See also, information at the end of this handbook about your appeal rights.

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 Service: 1-800-558-6213,

7 a.m. – 5 p.m. (CST) M-F

Report Fraud: 1-888-343-4221

Transplant Coordinator: 1-888-207-2421

Find in-network providers while traveling:

- Anywhere in the United States, call 1-800-810-BLUE (2583) or visit **bcbsglobalcore.com**
- Anywhere outside the United States, call 1-800-810-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 Care, Transition of Care and Continuity of 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

1-855-Here4TN (1-855-437-3486)

Pharmacy

CVS Caremark

1-877-522-8679

ParTNers for Health Wellness Program

1-888-741-3390

<http://go.activehealth.com/wellnesstn>

Member Portal

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

You can use this site to:

- Find providers
- Check your benefits and claim status
- 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

Register for a username and password at bcbst.com/members/TN_state. It's easy to access from your smartphone, tablet or computer. Once you register, you can:

- Check your benefits, including 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 PPO plans and almost all services under the state-sponsored CDHP/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 more details and look for information specific to your plan.

An **out-of-pocket maximum** limits how much you have to pay in any 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. Your eligible cost-sharing amounts, including your deductible, count toward your annual out-of-pocket maximum.

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
 - most prescription medications
- You pay deductible and coinsurance for things like:
 - inpatient hospital care
 - outpatient surgery
 - X-rays, labs and diagnostic tests
 - ambulance services
 - durable medical equipment

CDHP Plans

Your CDHP includes a tax-free HSA, which you own and can use to pay for qualified medical expenses. Qualified expenses may include things 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., certain medications to treat high blood pressure, diabetes, depression, high cholesterol, etc.).
- Your cost for prescription medications is the discounted network rate for the prescriptions until the deductible is met. Then you pay your coinsurance, which is a percentage of the discounted network rate.
- 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 filled and shipped. Otherwise, Caremark will charge the order to the credit card they have on file.

Health Savings Account (HSA)

When you enroll in a CDHP, a HSA will be opened for you automatically. The HSA is managed by **Optum Bank**, a company contracted by the state. Contact information is under the “Important Contact Information” section of this handbook. You own your HSA account, and it is your responsibility to register for your online account access at **optumbank.com/Tennessee**. The state will pay the monthly fee for your HSA while you are enrolled in the state’s CDHP. You must pay standard banking fees such as an ATM fee each time you use your HSA debit card at an ATM. If you leave your job, retire or choose a PPO option in the future, you must pay the monthly HSA fees. These fees will be taken from your HSA automatically.

You and your employer may put money into your HSA. The money saved in your HSA (both yours and any employer contributions) 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.

- You can put money into your HSA through online bank transfer or by mailing a check.
- In 2021, IRS guidelines allow total annual tax-free contributions up to \$3,600 for those with single coverage and \$7,200 for those with any other coverage. At age 55 and older, you can make an additional \$1,000/year contribution (\$4,600 for individuals or \$8,200 for families). The maximum includes any employer contribution.
- If you have questions about employer contributions, contact your human resources office or your agency benefits coordinator.
- Your full HSA contribution is not available up front at the beginning of the year or after you enroll. Your pledged amount is taken out of each paycheck each pay period (if payroll deduction is offered by your employer). You may only spend the money that is available in your HSA at the time of service or care.

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

- Use the Optum Bank 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 Optum Bank’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.

Optum Bank 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.

Go to www.tn.gov/partnersforhealth under Health Options and CDHP/HSA Insurance Options to learn more.

PPO Plans

Benefits at a Glance

Table 1: PPO PLANS – Services in this table **ARE NOT** subject to a deductible. \$ = your copayment amount; % = your coinsurance percentage; 100% covered or No Charge = you pay \$0 in-network. The Limited is open to Local Education and Local Government members only.

PPO HEALTH CARE OPTION	PREMIER		STANDARD		LIMITED	
COVERED SERVICES	In-Network ^[1]	Out-of-Network ^[1]	In-Network ^[1]	Out-of-Network ^[1]	In-Network ^[1]	Out-of-Network ^[1]
Preventive Care Office Visits						
Well-baby, well-child visits as recommended Adult annual physical exam Annual well-woman exam Immunizations as recommended Annual hearing and non-refractive vision screening Screenings including Pap smears, labs, nutritional guidance, tobacco cessation counseling and other services as recommended	No Charge	\$45	No Charge	\$50	No Charge	\$50
Outpatient Services	Services subject to a coinsurance may be extra					
Primary Care Office Visit						
Family practice, general practice, internal medicine, OB/GYN and pediatrics 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	\$25	\$45	\$30	\$50	\$35	\$55
Specialist Office Visit						
Including surgery in office setting Nurse practitioners, physician assistants and nurse midwives (licensed health care facility only) working under the supervision of a specialist	\$45	\$70	\$50	\$75	\$55	\$80
Behavioral Health and Substance Use (including virtual visits) ^[2]	\$25	\$45	\$30	\$50	\$35	\$55
Telehealth (approved carrier programs only)	\$15	N/A	\$15	N/A	\$15	N/A
Allergy Injection Without Office Visit	100% covered	100% covered up to MAC	100% covered	100% covered up to MAC	100% covered	100% covered up to MAC
Chiropractic and Acupuncture (limit of 50 visits of each per year)	Visits 1-20: \$25 Visits 21-50: \$45	Visits 1-20: \$45 Visits 21-50: \$70	Visits 1-20: \$30 Visits 21-50: \$50	Visits 1-20: \$50 Visits 21-50: \$75	Visits 1-20: \$35 Visits 21-50: \$55	Visits 1-20: \$55 Visits 21-50: \$80
Convenience Clinic	\$25	\$45	\$30	\$50	\$35	\$55
Urgent Care Facility	\$45	\$70	\$50	\$75	\$55	\$80
Emergency Room Visit	\$150		\$175		\$200	
Pharmacy						
30-Day Supply (generic preferred brand non-preferred)	\$7 \$40 \$90	copay plus amount exceeding MAC	\$14 \$50 \$100	copay plus amount exceeding MAC	\$14 \$60 \$110	copay plus amount exceeding MAC
90-Day Supply (generic preferred brand non-preferred)						
90-day network pharmacy or mail order	\$14 \$80 \$180	N/A – no network	\$28 \$100 \$200	N/A – no network	\$28 \$120 \$220	N/A – no network
Certain maintenance medications from 90-day network pharmacy or mail order ^[3]	\$7 \$40 \$160	N/A – no network	\$14 \$50 \$180	N/A – no network	\$14 \$60 \$200	N/A – no network
Specialty Medications (30-day supply from a specialty network pharmacy)	In-Network for all plans = 10%; minimum \$50; maximum \$150 Out-of-Network for all plans = NA – no network					

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.

PPO HEALTH CARE OPTION	PREMIER		STANDARD		LIMITED	
COVERED SERVICES	In-Network ^[1]	Out-of-Network ^[1]	In-Network ^[1]	Out-of-Network ^[1]	In-Network ^[1]	Out-of-Network ^[1]
Preventive Care – Outpatient Facilities						
Screenings including colonoscopy, mammogram, colorectal, bone density scans and other services as recommended	No Charge ^[5]	40%	No Charge ^[5]	40%	No Charge ^[5]	50%
Other Services						
Hospital/Facility Services^[4]						
Inpatient care; outpatient surgery Inpatient behavioral health/substance use ^{[2] [6]}	10%	40%	20%	40%	30%	50%
Maternity (Global billing for labor and delivery and routine services beyond initial office visit)	10%	40%	20%	40%	30%	50%
Home Care^[4] (Home health; home infusion therapy)	10%	40%	20%	40%	30%	50%
Rehabilitation and Therapy Services						
Inpatient and skilled nursing facility ^[4] ; outpatient Outpatient IN-NETWORK physical, occupational and speech therapy ^[5]	10%	40%	20%	40%	30%	50%
X-Ray, Lab and Diagnostics (not including advanced X-rays, scans and imaging) ^[5]	10%		20%		30%	
Advanced X-Ray, Scans and Imaging (including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies) ^[4]	10%	40%	20%	40%	30%	50%
All Reading, Interpretation and Results^[5]	10%		20%		30%	
Ambulance (air and ground)	10%		20%		30%	
Equipment and Supplies^[4]						
Durable medical equipment and external prosthetics Other supplies (i.e. ostomy, bandages, dressings)	10%	40%	20%	40%	30%	50%
Also Covered	Certain dental benefits, hospice care and out-of-country charges – See separate sections in this handbook for details					
Deductible						
Employee Only	\$500	\$1,000	\$1,000	\$2,000	\$1,800	\$3,600
Employee + Child(ren)	\$750	\$1,500	\$1,500	\$3,000	\$2,500	\$4,800
Employee + Spouse	\$1,000	\$2,000	\$2,000	\$4,000	\$2,800	\$5,500
Employee + Spouse +Child(ren)	\$1,250	\$2,500	\$2,500	\$5,000	\$3,600	\$7,200
Out-of-Pocket Maximum	medical and pharmacy combined – eligible expenses, including deductible, count toward the out-of-pocket maximum					
Employee Only	\$3,600	\$4,000	\$4,000	\$4,500	\$6,800	\$10,400
Employee + Child(ren)	\$5,400	\$6,000	\$6,000	\$6,750	\$13,600	\$20,800
Employee + Spouse	\$7,200	\$8,000	\$8,000	\$9,000	\$13,600	\$20,800
Employee + Spouse +Child(ren)	\$9,000	\$10,000	\$10,000	\$11,250	\$13,600	\$20,800

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 unless otherwise noted in this handbook or the Plan document.

[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 behavioral health services including, but not limited to, applied behavioral analysis, transcranial magnetic stimulation, electroconvulsive therapy, psychological testing, and other behavioral health services as determined by the Contractor’s clinical staff.

[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), depression and some osteoporosis medications.

[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.

[6] Select Substance Use Treatment Facilities are preferred with an enhanced benefit - members won't have to pay a deductible or coinsurance for facility-based substance use treatment; Copays will apply for standard outpatient treatment services. Call 855-Here4TN for assistance.

CDHP Plans

Benefits at a Glance

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

CDHP/HSA HEALTH CARE OPTION	CDHP/HSA State and Higher Education		LOCAL CDHP/HSA Local Education & Local Government	
	In-Network ^[1]	Out-of-Network ^[1]	In-Network ^[1]	Out-of-Network ^[1]
COVERED SERVICES				
Preventive Care Office Visits				
Well-baby, well-child visits as recommended Adult annual physical exam Annual well-woman exam Immunizations as recommended Annual hearing and non-refractive vision screening Screenings including Pap smears, labs, nutritional guidance, tobacco cessation counseling and other services as recommended	No Charge	40%	No Charge	50%
Outpatient Services				
Primary Care Office Visit				
Family practice, general practice, internal medicine, OB/GYN and pediatrics 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	20%	40%	30%	50%
Specialist Office Visit				
Including surgery in office setting Nurse practitioners, physician assistants and nurse midwives (licensed health care facility only) working under the supervision of a specialist	20%	40%	30%	50%
Behavioral Health and Substance Use ^[2] (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 and Acupuncture (limit of 50 visits of each per year)	20%	40%	30%	50%
Convenience Clinic	20%	40%	30%	50%
Urgent Care Facility	20%	40%	30%	50%
Emergency Room Visit	20%		30%	
Pharmacy				
30-Day Supply (generic preferred brand non-preferred)	20%	40% plus amount exceeding MAC	30%	50% plus amount exceeding MAC
90-Day Supply (generic preferred brand non-preferred)				
90-day network pharmacy or mail order	20%	N/A – no network	30%	N/A – no network
Certain maintenance medications from 90-day network pharmacy or mail order ^[3]	10% without first having to meet deductible	N/A – no network	20% without first having to meet deductible	N/A – no network
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.

CDHP/HSA HEALTH CARE OPTION	CDHP/HSA State and Higher Education		LOCAL CDHP/HSA Local Education & Local Government	
COVERED SERVICES	In-Network ^[1]	Out-of-Network ^[1]	In-Network ^[1]	Out-of-Network ^[1]
Preventive Care – Outpatient Facilities				
Screenings including colonoscopy, mammogram, colorectal, bone density scans and other services as recommended	No Charge	40%	No Charge	50%
Other Services				
Hospital/Facility Services ^[4]				
Inpatient care; outpatient surgery Inpatient behavioral health/substance use ^{[2][5]}	20%	40%	30%	50%
Maternity (Global billing for labor and delivery and routine services beyond initial office visit)	20%	40%	30%	50%
Home Care ^[4] (Home health; home infusion therapy)	20%	40%	30%	50%
Rehabilitation and Therapy Services				
Inpatient and skilled nursing facility ^[4] ; outpatient	20%	40%	30%	50%
X-Ray, Lab and Diagnostics (not including advanced X-rays, scans and imaging)	20%	40%	30%	50%
Advanced X-Ray, Scans and Imaging (including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies) ^[4]	20%	40%	30%	50%
All Reading, Interpretation and Results	20%		30%	
Ambulance (air and ground)	20%		30%	
Equipment and Supplies ^[4]				
Durable medical equipment and external prosthetics Other supplies (i.e. ostomy, bandages, dressings)	20%	40%	30%	50%
Also Covered	Certain dental benefits, hospice care and out-of-country charges – See separate sections in this handbook for details			
Deductible				
Employee Only	\$1,500	\$3,000	\$2,000	\$4,000
Employee + Child(ren)	\$3,000	\$6,000	\$4,000	\$8,000
Employee + Spouse	\$3,000	\$6,000	\$4,000	\$8,000
Employee + Spouse +Child(ren)	\$3,000	\$6,000	\$4,000	\$8,000
Out-of-Pocket Maximum	medical and pharmacy combined – eligible expenses, including deductible, count toward the out-of-pocket maximum			
Employee Only	\$2,500	\$4,500	\$5,000	\$8,000
Employee + Child(ren)	\$5,000	\$9,000	\$10,000	\$16,000
Employee + Spouse	\$5,000	\$9,000	\$10,000	\$16,000
Employee + Spouse +Child(ren)	\$5,000	\$9,000	\$10,000	\$16,000
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. The deductible and out-of-pocket maximum amount can be met by one or more persons but must be met in full before it is considered satisfied for the family. No one family member may contribute more than \$8,550 to the in-network family out-of-pocket maximum total. See the "Out of Pocket Maximums" section in the Member Handbook for more details. Coinsurance is after deductible is met unless otherwise noted.

- [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 behavioral health services, including but not limited to applied behavioral analysis, transcranial magnetic stimulation, electroconvulsive therapy, psychological testing, and other behavioral health services as determined by the Contractor's clinical staff.
- [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), depression and some osteoporosis medications.
- [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] Select Substance Use Treatment Facilities are preferred with an enhanced benefit - members must meet their deductible first, then coinsurance is waived. Deductible/coinsurance for CDHP will apply for standard outpatient treatment services. Call 855-Here4TN for assistance.

Engaging in Your Health Care

Blue Distinction Specialty Care®

When you or your family need specialty care, you want the best available. Blue Distinction 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.

	Blue Distinction Centers	Blue Distinction Centers+
Quality care	✓	✓
Treatment expertise	✓	✓
Better overall patient results	✓	✓
More affordable care		✓

To find out if a Blue Distinction provider is in your network, contact us at **1-800-558-6213**. You can also visit **bcbs.com/blue-distinction-center/facility** for more information.

When viewing the BlueCross BlueShield of Tennessee site, be aware that:

- * Bariatric facilities available to you may be different than those those listed on this BlueCross BlueShield of Tennessee site. Call BlueCross BlueShield of Tennessee to learn about your bariatric coverage.
- ** 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

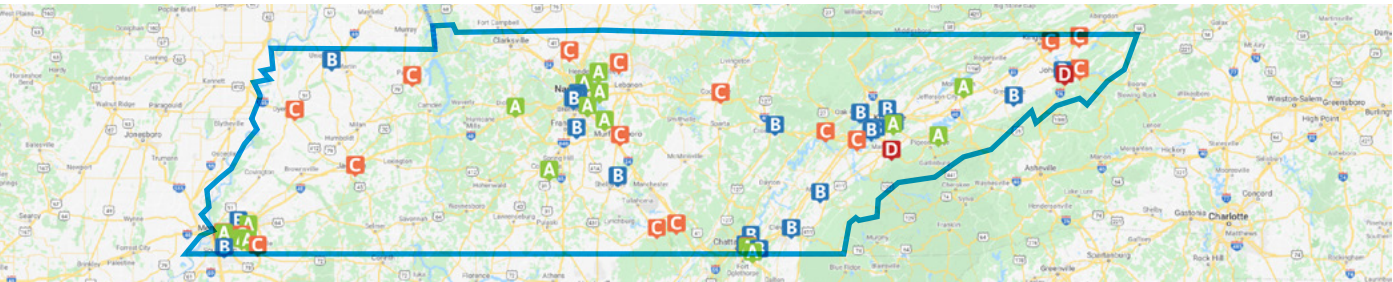
These resources can help you and your family find the best place to receive high-quality care. They also offer suggestions about questions to ask your doctor and how to talk with your doctor about choosing what health care you need and which medical tests and treatments you may not need.

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. **tn.gov/partnersforhealth/know-your-health**

- **Leapfrog Hospital Safety Grade** — A consumer-friendly letter grade rating of hospitals on their records of patient safety. **hospitalsafetygrade.org**. Grades are updated twice annually, in the fall and spring.

Spring 2020 Tennessee Hospital Safety Grades

- **Compare Hospitals** — Interactive tool that helps you choose the best hospital for you. **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. **choosingwisely.org**



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 www.tn.gov/partnersforhealth. Phone numbers are also provided under the “Important Contact Information” section of this handbook.

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**

Medical Benefit Reminders

- **In-network preventive care** – There is no charge to you, but you will be responsible for your share of the cost if your provider bills for something other than preventive care.
- **Ask early if you don't know.** 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.

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.
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 **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.

Availability of benefits should be verified with the claims administrator prior to incurring charges for these services.

- 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, 162 mg 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 the nearest general hospital, specialty hospital, or facility which is equipped to furnish the approved medically necessary 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.
 14. Charges for medically necessary surgical procedures.
 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.
 - 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.
23. **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.
24. **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.
25. ***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.
 - 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.

***Reminder:**

– **Physical, Occupational and Speech**

Therapies — PPO members don't 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.

26. 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.
27. 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.
28. Bone anchored hearing devices. Covered persons or their provider must obtain prior authorization.
29. The first contact lenses or glasses (excluding tinting and scratch resistant coating) purchased after cataract surgery (including examination charge and refraction).
30. 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.
31. 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.
32. Continuous passive motion machine for knee replacement surgery or anterior cruciate ligament repair for up to 28 days after surgery.
33. 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.
34. 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.
35. 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.
36. "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.
37. 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.

38. Charges for treatment received by a licensed doctor of podiatric medicine or for treatment by a licensed doctor of chiropractic or acupuncture provided treatment was within the scope of his/her license, unless listed as an exclusion.
39. Routine foot care for diabetics including toenail clipping and treatment for corns and calluses.
40. 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.
41. 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.
42. 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.
43. 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.
44. 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.
45. 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 or damage (other than by eating or chewing) to sound natural teeth and/or jaw. Damage means deterioration or loss documented to be the direct result of medically necessary treatment that significantly impairs a covered person's ability to masticate and maintain a healthy weight. 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.
46. Eligible medical expenses for treatment of Autism Spectrum Disorders as specified in TCA 56-7-2367.
47. Routine patient costs related to clinical trials as defined by TCA 56-7-2365.
48. Charges for laser procedures, other than those specifically excluded.
49. 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 will be responsible for charges or services from in-network providers determined to be experimental, investigational, or unproven if they have signed a waiver accepting responsibility for the costs of those charges or services.)
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 exists.
 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 provider. There is also no 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. You will save money and get the most from your benefits if you use in-network providers.

While you are not required to select a primary care provider, you should seek routine care from the same primary-type provider whenever possible. This helps establish your medical home.

A primary care provider can be a general practitioner, a doctor who practices family medicine, internal medicine, pediatrics or an OB/GYN. Nurse practitioners, physician assistants and nurse midwives may also be considered primary-type providers when working under the supervision of a primary care provider.

Members sometimes 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 an in-network provider 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 for you to contact us to confirm benefits for hospital admissions or other services that require prior authorization.

If you need help finding and scheduling an appointment with an in-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 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.

You must go through **PhysicianNow® Powered by MDLIVE** to use your telehealth benefits.

There is no coverage for telephone consultations, unless you use **PhysicianNow** through BlueCross BlueShield.

Pre-registration is very helpful so you can access telehealth services quickly when you need them. Call member services if you have any questions or need help signing up.

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.

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 every year, then that service will be covered once anytime within the plan year. Services must be considered medically necessary and are subject to any plan limits.

Maternity Benefits

Coverage for maternity benefits involves an initial office visit cost to verify the pregnancy. Later 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.

Plan	Coverage
Premier PPO	100% covered
Standard PPO	100% covered
Limited PPO	100% covered
CDHP/HSA	100% covered after deductible
Local CDHP/HSA	100% covered after deductible

Dental Treatment

Your medical plan covers certain limited benefits for dental treatment — orthodontic treatment for the correction of facial hemiatrophy or congenital birth defect which impairs a bodily function, extraction of impacted wisdom teeth, excision of solid-based oral tumors, eligible expenses for Temporomandibular Joint Malfunction (TMJ), and accidental injury or damage to sound natural teeth (other than by eating or chewing). Damage means deterioration or loss documented to be the direct result of medically necessary treatment that significantly impairs a covered person’s ability to masticate and maintain a healthy weight. Charges for the facility and related medical services are also covered when hospitalization for dental services is determined medically necessary by the claims administrator. See the Covered Expenses and Excluded Services sections in this handbook for more details.

Member Costs by Plan:

All benefits are after plan deductible.

Plan	Oral Surgeons		Non-Contracted Providers (i.e., dentists, orthodontists)
	In-Network	Out-of-Network	
Premier PPO	10%	40%	10%
Standard PPO	20%	40%	20%
Limited PPO	30%	50%	30%
CDHP/HSA	20%	40%	20%
Local CDHP/HSA	30%	50%	30%

Transplant Benefits

Prior authorization is required for ALL transplants. Your plan provides cost savings if you have an approved transplant at:

- A BCBS Blue Distinction Center of Excellence (COE); or
- An in-network approved facility if there is no BCBS Blue Distinction COE for the type of transplant you need

If you elect to have covered transplant services at another facility when there is a BCBS Blue Distinction COE option, you will pay the usual member cost share.

Call BlueCross Member Service at 1-800-558-6213 for more information.

Plan	Cost Savings	Usual In-Network Member Share
Premier PPO	100% covered	Deductible plus 10% coinsurance
Standard PPO	100% covered	Deductible plus 20% coinsurance
Limited PPO	100% covered	Deductible plus 30% coinsurance
CDHP/HSA	100% covered after deductible	Deductible plus 20% coinsurance
Local CDHP/HSA	100% covered after deductible	Deductible plus 30% coinsurance

Plan Deductible

A plan 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. There is also 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 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 for in-network expenses only. 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 \$8,550. Once a family member has eligible in-network out-of-pocket costs totaling \$8,550, the plan will cover that family member’s eligible in-network expenses at 100 percent for the remainder of the plan year. All other family members will contribute to the remaining overall family out-of-pocket limit which must be met before the plan covers the family’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.

Note: 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

You are enrolled in BlueCross Network S.

In-network benefits apply when you receive care from doctors and hospitals participating in BlueCross Network S. Receiving in-network care allows the highest level of benefits.

You can receive care from providers who do not participate in Network S, but in most cases, reduced out-of-network benefits will apply. Also, you will be required to pay the difference between the maximum allowable charge (MAC) and the actual charge.

See the next page for sections on emergency care and hospital-based providers at in-network facilities.

Reminder: Your health care coverage does not allow payment if BlueCross determines a service is not or was not medically necessary for your condition.

Maximum Allowable Charge Defined

In the simplest terms, the MAC is the maximum amount that BlueCross will pay to a particular provider for a particular service. Providers who have contracted with us to provide in-network services have agreed to accept that amount as payment in full. This means they write off the rest of the charge after any applicable cost is paid by the member. Out-of-network providers have not agreed to the contracted rate and may balance bill you for the amount above the MAC.

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 search for a provider online or refer to a provider directory to find in-network facilities.

Convenient care clinics can help with common conditions like burns and sprains, sinus infections, sore throats, skin rashes and upset stomachs. These types of 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 injuries or illnesses, like urinary tract infections, 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. 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.

The emergency room (ER) should be used only in the case of an emergency or for urgent care as directed by your doctor. The highest level of benefits is available for any emergency room visit that meets the definition of an emergency explained below. Be sure to ask if the facility is in-network or call us to confirm. If out-of-network

facilities or providers are used, you may be billed for amounts exceeding the allowable charge (maximum amount eligible for payment). You will be responsible for those amounts if it is determined that the situation was not an emergency or not medically necessary. If your situation was determined to be an emergency and you receive a bill for amounts exceeding the allowable charge from an out-of-network provider, call BlueCross and they will provide you with assistance to make sure you are not responsible for those amounts.

If you receive a bill for emergency services asking you to pay more than you expected to pay, call BlueCross Member Service. Be prepared to provide a copy of the bill you received, and ask for a review of your claim to see if insurance can pay anything more.

An “emergency” medical condition is an illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn’t get medical attention right away. If you didn’t get immediate medical attention you could reasonably expect one of the following:

- Your health would be put in serious danger (or, with respect to pregnant women, the health of the woman or her unborn child)
- You would have serious problems with your bodily functions, or
- You would have serious damage to any part or organ of your body

For each covered emergency room visit, you will pay your portion of the emergency room cost. If you are admitted for more than 23 hours the emergency room visit is considered part of your inpatient services. 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, the visit is included in your original emergency room costs.

If you also receive services such as an MRI or CT, you will be charged for those services in addition to your emergency room visit. Should an out-of-network ER require you to pay in full, 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 should make the necessary arrangements at an in-network facility. Be sure to ask if the facility is in-network or call us to confirm. Your doctor should also coordinate your care and prior authorization with our office. 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. This allows your doctor to make necessary arrangements for any follow-up care. Maternity admissions do not require pre-authorization.

Hospital-Based Providers at In-Network Facilities

Hospital-based providers are not employed by the hospital but may provide medical services and care for you at a hospital. Sometimes hospital-based providers are out-of-network, even at an in-network facility. These hospital-based providers include, but are not limited to, emergency room physicians, anesthesiologists, radiologists and pathologists.

You are eligible for in-network benefits for covered services received from these providers.

Claims for these types of services may not process to apply in-network benefits the first time. If you receive a bill from one of these out-of-network hospital-based providers that you saw at an in-network facility, and you are asked to pay more than you expected, call BlueCross Member Service. BlueCross will provide you with assistance to make sure you are not responsible for those amounts. You may be asked to provide a copy of the bill you received from the provider.

Utilization Management (UM)

Utilization management programs review requirements and determine authorization for payment of benefits. Programs include:

- Pre-admission certification
- Post-certification of emergency admissions
- Weekend admissions
- Optional second surgical opinions
- Certain outpatient procedures
- Home health
- Case management
- Private duty nursing
- Durable medical equipment
- Pharmacy program

These programs are used to determine payment of benefits. They are not meant to supersede the physician/patient relationship. The level and duration of medical care is always the patient's decision in conjunction with his/her physician.

UM decisions are based only on medical appropriateness of care/service and coverage eligibility. The UM organization does not reward practitioners or other individuals for issuing denials of coverage or care.

Prior Authorization

Prior authorization (PA) is designed to encourage the delivery of medically necessary services in the most appropriate setting, consistent with the medical needs of the member and with patterns of care in an established managed care environment for treatment of a particular illness, injury or medical condition.

PA is required for certain services including some of the more common specific services listed below.

Some services are included in broader categories that appear on the list, like inpatient hospital services and specialty medications. Contact BlueCross Member Service before receiving services if you have a question about benefits requiring prior authorization:

- Inpatient hospital services
- Skilled nursing facility stays
- Home health care
- 23-Hour observation (when elective, direct admission from MD office and transfer from another facility)
- Hospice
- Home infusion therapy (certain drugs)
- Private duty nursing
- Advanced X-rays, scans, and imaging
- Durable medical equipment (certain equipment greater than \$500)
- Chemotherapy and radiation therapies
- Provider Administered Specialty Medications (administered in provider offices, inpatient and outpatient hospitals, infusion centers, home health, etc. and not at a pharmacy)
- Non-emergent ambulance transport (air and ground)
- Certain musculoskeletal procedures (including, but not limited to, spinal surgeries, spinal injections, and hip, knee and shoulder surgeries)
- Neonatal ICU
- Advanced therapeutics used to treat or cure genetic conditions
- Bariatric
- Transplants
- Genetic testing – certain outpatient genomic and molecular testing
- Hysterectomy
- Endometrial ablation
- Varicose veins
- Blepharoplasty/browplasty
- Breast surgery for augmentation or reduction
- Hyperbaric treatments
- Panniculectomy

All providers for the above services should request these authorizations prior to delivering services. If an in-network provider does not obtain required authorization, no benefits will be paid, and both the plan and the covered person shall be held harmless.

Out-of-network providers are not contracted. If you receive medically or clinically necessary care from an out-of-network provider, you are responsible

for verifying with BlueCross that required prior authorizations have been requested and approved before receiving care.

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.

PA is not required for maternity admissions or emergency services.

BlueCross does not manage PA for pharmacy benefits or behavioral health and substance use treatment. Contact information for those programs is provided under the "Important Contact Information" section of this handbook.

Advanced Radiological Imaging

PA is required for certain non-routine diagnostic services and the setting for such services.

BlueCross will coordinate review for 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 (DME)

The plan covers certain durable medical equipment determined to be medically necessary on the basis of an individual's medical and physical condition.

Some equipment requires prior authorization (PA). Generally, PA only applies to more expensive items. Providers should request PA, if needed, before 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 may 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 (COB) With Other Insurance Plans

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**.

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.

COB will be applied to your claims so that:

- If you have other primary medical coverage, and secondary medical coverage with this plan, you will pay any cost share required by this plan.
- If you have primary and secondary coverage with this plan, you will pay the cost share required by this plan's secondary coverage

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.

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

Three types of exceptions – Unique Care, Transition of Care and Continuity of Care — may be granted. These exceptions allow benefits to 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 by BlueCross. Exceptions will be granted only for medical necessity, not for convenience. To apply for an 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 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 an in-network facility or provided by an in-network physician

Unique Care

A unique care exception can be granted for treatment not routinely available from an in-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 an in-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. 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.

When unique care exceptions are granted, a time frame for this approval is given. If more time for unique care is needed 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 unique care approval extension request will include a review of the available network to determine if the required care can now be accessed within the network.

Transition of Care

With Transition of Care, you may be able to continue to receive services for specified medical conditions with health care providers who are not in the BCBS network at in-network coverage levels. This care is for a defined period of time until the safe transfer of care to an in-network provider or facility can be arranged. You must apply for Transition of Care at enrollment, or when there is a change in your medical plan. You must apply no later than 30 days after the effective date of your coverage. To apply, complete the **Medical Transition of Care request form** found on the BCBS member web page, or call BCBS for assistance.

Continuity of Care

With Continuity of Care, you can receive services at in-network coverage levels for specified medical conditions when your health care provider leaves your plan's network and the immediate transfer of your care to another health care provider would be inappropriate and/or unsafe. This care is for a defined period of time. You must apply for Continuity of Care within 30 days of your health care provider's termination date. This is the date that he or she is leaving your plan's network. To apply, complete the **Medical Transition of Care request form** found on the BCBS member web page, or call BCBS for assistance.

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.

For PPO plan members, 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 an in-network provider is used. **CDHP plan members** must first meet the annual deductible requirement.

The payment in full provision does not apply to the CDHP healthcare options unless annual deductible requirements have already been met.

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

BlueCross is responsible for all medical plan claims processing. When you visit an in-network doctor or facility, be sure to show your identification card.

The provider will file your claim directly. These in-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 services.

If you visit an out-of-network doctor or facility, you may be responsible for filing claims yourself. Out-of-network providers may also require payment in full at the time of service. The correct form must be used and a separate claim form must be completed for each individual who 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.

BlueCross is not responsible for processing claims for pharmacy or behavioral health and substance use treatment. Contact information for those programs is provided under the "Important Contact Information" section of this handbook.

Out-of-State Providers

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

Out-of-Country Care

When traveling outside of the United States for business or pleasure, eligible expenses incurred for medically necessary emergency and urgent care services are covered at the in-network level. Other medically necessary care will be covered at the out-of-network level. No benefits will be paid if a covered person travels to another country for the purpose of seeking medical treatment outside the United States. Claims from a non-English speaking country should be translated to standard English at the covered person's expense.

Claim forms should contain valid procedure and diagnosis codes and include the current exchange rate, if available, before being submitted for payment.

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

1. Always carry your BlueCross BlueShield of Tennessee identification card.
2. Check with member services at **1-800-558-6213** before leaving the U.S.
3. If you need emergency medical care, go to the nearest hospital. Call the BlueCross BlueShield Global CoreSM Service Center at **1-800-810 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 BlueCross BlueShield Global Core Service Center. The Service Center will facilitate hospitalization at a BlueCross BlueShield Global Core hospital or make an appointment with a doctor. It is important that you call the BlueCross BlueShield 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.

Out-of-Country Benefits non-emergency and non-urgent care	
Out-of-Network benefits only; deductible applies	
Plan	Coinsurance
Premier PPO	40%
Standard PPO	40%
Limited PPO	50%
CDHP/HSA	40%
Local CDHP/HSA	50%

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. To see your discounts, log in to your account. Then, click **Managing Your Health** and select **Member Discounts & Fitness Your Way**. You can also find information about your discounts using your MyBlueTN app.

You can save on:

- Apparel & Footwear
- Fitness
- Hearing & Vision
- Home & Family
- Nutrition
- Personal Care
- Travel

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 **1-877-522-8679** for further information or visit **info.caremark.com/stateoftn**

Once there, you can view the State of Tennessee Group Insurance Program Prescription Drug List, Specialty Drug List, Vaccine Network Pharmacy List, Medications Requiring Prior Authorization for Medical Necessity, Hyperinflation Management Drug List and the Retail-90 Network Pharmacy List. 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.

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) diabetes (oral medications, insulins, needles, test strips and lancets) and some osteoporosis medications.

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 plan discounted 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 Performance 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 get 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 **1-877-522-8679**. 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 BlueCross (medical benefits) for more information or go to **tn.gov/partnersforhealth** and click on Pharmacy.

Here4TN Behavioral Health, Substance Use and Employee Assistance Program

New Resources:

- **Sanvello**, an on-demand mobile app to help with stress, anxiety and depression
- **Talkspace**, online therapy including text, audio, and video within a secure app.

Learn more at **Here4TN.com**

You and your dependents enrolled in health coverage are eligible for behavioral health and substance use benefits, which are administered by Optum Health. Optum can be reached toll-free at **1-855-Here4TN (1-855-437-3486)** any time, day or night, to speak confidentially with a trained professional for a referral. Services generally include the following:

- Outpatient assessment and treatment
- Virtual Visits — visits with a provider through private, secure video conferencing
- Inpatient assessment and treatment
- Enhanced benefit for facility-based substance use treatment at select facilities — call **1-855-Here4TN** for assistance
- Partial hospitalization
- Residential treatment
- Intensive outpatient treatment and
- 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 an in-network provider and obtain prior authorization for inpatient services as well as some outpatient services including psychological testing, electro-convulsive treatment, Applied Behavior Analysis, and transcranial magnetic stimulation.

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). EAP sessions are issued and authorized on a per-problem-per-year-per-person basis. For example the member receives five EAP counseling sessions for each problem. Should a different unrelated problem arise within the same plan year, the member would receive an additional five sessions to address the new problem. A different problem is either: 1) a new issue for which the member has received no previous counseling or 2) an existing issue that has not been treated in that plan year. Examples of different problems (not an exhaustive list): Relationship issues, Job stress, Parenting issues, Caregiving of a loved one, and Death of a loved one. 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 **1-855-Here4TN (1-855-437-3486)**. The website provides valuable health information, tools and resources to help with life's challenges as well as opportunities. This site offers you the ability to take self-assessment tests, on-line trainings, search for providers, access a map of your provider's location, and 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. This includes viewing 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 **1-855-437-3486**.

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 2021.

Go to **<http://go.activehealth.com/wellnesstn>** for updates.

- State and higher education members and enrolled spouses 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 access to a health assessment, coaching support (online personal or group coaching, or by phone) for disease management programs such as asthma, diabetes, congestive heart failure (CHF), coronary artery disease (CAD) and chronic obstructive pulmonary disease (COPD). You will get emails about coaching support that's available to you. It is completely voluntary and won't cost you anything. In addition you will have access to the web portal and mobile app where you can get access to your coaches, the health assessment and tips and trackers.
- There is also a Diabetes Prevention Program (DPP) for those who are pre-diabetic and qualify for the program. In addition to the ParTNers For Health DPP, BlueCross is partnering with Livongo to offer an online diabetes prevention program. It is FREE to eligible members and their dependents age 18 and older to help manage your weight and reduce your risk of developing type 2 diabetes. To see if you qualify for the program, log in to your account. If you have questions, call **1-888-599-7483**. Be sure to have your BlueCross Member ID with you when you call.



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 in-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 copay, 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.

Appeals

Information in this section does not apply to any complaint alleging possible professional liability, commonly known as malpractice, or for any complaint concerning benefits provided by any other plan. In the event of a conflict between information in this handbook and applicable state or federal law, the applicable law shall control.

The appeals process follows Federal rules and regulations and assigns appeal responsibilities to the carriers and independent review organizations.

For more information see the State, Local Education or Local Government Plan Documents at www.tn.gov/partnersforhealth. Look under the Publications tab and Medical Plan Documents.

You may submit any appeals described in the sections that follow with or without the help of an authorized person or personal representative.

The plan does not provide an appeal process for providers, does not review disputes under a provider contract with a claims administrator, and does not permit covered persons to assign appeal rights to a provider. A provider may help you prepare an appeal but shall not become a party to the appeal. Providers may appeal to claims administrators on their own behalf if permitted by an agreement between the provider and the claims administrator or state or federal law. Such appeals are outside of appeal or administrative remedies provided under this plan.

Call First

You can call with or without help from an authorized person or personal representative. A telephone call does not constitute an appeal, but a call should be made as soon as possible upon learning of any enrollment or premium issue or denial of payment or medical services. **Call as soon as possible for faster resolution and to avoid missing deadlines.**

Enrollment or Premium Issues – Call Benefits Administration at 1-800-253-9981 or visit tn.gov/partnersforhealth.

Medical Services or Payment Issues — call the telephone number listed on your insurance card. The separate phone numbers for behavioral health and substance use, pharmacy and medical can also be found at the front of this handbook under **"Important Contact Information" on page 8.**

Deadline To File Appeals

If an issue is not resolved and you want to start an appeal, **you have one hundred eighty (180) calendar days** after you receive notice of an adverse determination.

Enrollment and Premium Appeals

Contact Benefits Administration at Benefits.Administration@tn.gov, or write to:
State of Tennessee, Department of Finance and Administration, Benefits Administration
312 Rosa L. Parks Avenue, Suite 1900
William R. Snodgrass Tennessee Tower
Nashville, TN 37243-1102

- Enrollment and premium appeals are submitted to and decided by the Benefit Administration Review Team (BART)
- No external administrative appeal is provided
- An enrollment appeal cannot be utilized to make mid-year benefit election changes not otherwise permitted by the plan
- A retroactive termination of enrollment that meets the definition of "rescission" under 45 CFR147.128 is appealable and shall be resolved in accordance with Federal law

Behavioral Health and Substance Use Appeals

Contact Optum at **1-855-437-3486** for EAP, behavioral health and substance use appeals or write to:

Optum Appeals and Grievances
P.O. Box 30512
Salt Lake City, UT 84130-0512
Fax: 855-312-1470

Pharmacy Appeals

Contact CVS Caremark at **1-877-522-8679** for pharmacy appeals or write to:

CVS Caremark Appeals Department MC109
P.O. Box 52084
Phoenix, AZ 85072-2084

Please include: your name and member ID number, doctor's name and telephone number, name of medication and information relevant to your appeal.

Medical Service Appeals

If you are in disagreement with a coverage decision or the way a claim has been paid or processed, you should **first call BCBS member services at 1-800-558-6213** to discuss the issue.

First Internal Appeal — If the issue cannot be resolved through member services, you may file an appeal/member grievance.

You will have 180 days to start an internal appeal with BlueCross BlueShield following notice of an adverse determination

The appeal/grievance form can be found on the BlueCross BlueShield of Tennessee Member Home Page at **bcbst.com/members/tn_state**. Once a determination is made, you will be notified in writing and advised of any further appeal options and timeframes for filing additional appeals. All requests must be filed within the specified timeframes.

Second Internal Appeal — In addition to the initial internal appeal, you may initiate a second internal appeal within one hundred and eighty (180) calendar days from receipt of an adverse determination of the initial appeal.

External Review — When an appeal decision made by BlueCross BlueShield is unfavorable and the appeal qualifies for external review, BlueCross BlueShield will advise you, of the right to initiate an external appeal. External appeals are considered by an Independent Review Organization (IRO).

If you choose to pursue an external appeal, you must submit a request within four months of the notice of the appeal decision you receive from BlueCross BlueShield.

Expedited Reconsideration — 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 you may request an expedited reconsideration. If the treating provider fails to request the reconsideration and decides not to provide urgently needed services, then you, or your authorized representative, may request the expedited reconsideration. If BlueCross BlueShield agrees that it is appropriate to conduct an expedited reconsideration, we will inform the you 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 only applies 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 after receipt of the appeal for denials of non-urgent care not yet received
- 60 days after receipt of the appeal 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. Anywhere in the United States, call **1-800-810-BLUE (2583)** or **visit bcbsglobalcore.com**

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 in-network care to you. If specialty care is not available at the contracted in-network hospital(s), arrangements will be made to the appropriate out-of-network hospital. A request for unique care exception benefits may be required.

Q I received a bill from an out-of-network provider that I wasn't expecting. What can I do?

A Call BlueCross. We will review your claim and EOB with you to determine and explain your cost share. You may be asked to provide a copy of the bill from the provider. In some

cases you may not be responsible for expenses which exceed the maximum allowable charge. See pages 28 and 29 for more information on emergency care and hospital-based providers.

Q What if I must reach my physician after regular office hours or 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. 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 nurse or doctor will be able to help you. They may 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.

Q How do I receive services covered by the Barry Brady Act?

A If you are a firefighter who qualifies for additional health screenings under the Barry Brady Act and your related claims process with unexpected member cost share, call BCBS customer service and request a reconsideration of your claims.

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:

- 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 1-800-565-9140 (TTY: 1-800-848-0298 or 711). They can provide you with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address your Nondiscrimination Grievance to: Nondiscrimination 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).

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

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

The PhysicianNow program operates subject to state regulation and may not be available in certain states.

PhysicianNow phone consultations are available 24/7 while video consultations are available during the hours of 7 a.m. to 9 p.m. seven days a week or by scheduled availability. MDLive is an independent internet based service that allows consumers to select and interact with independent physicians and other health care providers. For complete terms of use, visit: welcome.mdlive.com/terms-of-use.

The App Store is a registered trademark of Apple, Inc. Android is a trademark of Google, Inc.

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

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-558-6213 (رقم هاتف الصم والبكم: 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)。

CHÚ Ý: 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).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-558-6213 (TTY: 1-800-848-0298) 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-558-6213 (ATS : 1-800-848-0298).

ប្រសិនបើ អ្នកនិយាយភាសាខ្មែរ ឬភាសាខ្មែរ មានសេវាបន្ថែម ដើម្បីជួយអ្នកក្នុងការប្រើប្រាស់ភាសាខ្មែរ ឬភាសាខ្មែរ ដោយឥតគិតថ្លៃ។ ហៅលេខ 1-800-558-6213 (TTY: 1-800-848-0298) ។

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚክተለው ቁጥር ይደውሉ 1-800-558-6213 (መስማት ለተሳናቸው: 1-800-848-0298)፡፡

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-558-6213 (TTY: 1-800-848-0298).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-558-6213 (TTY: 1-800-848-0298)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。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).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-558-6213 (TTY: 1-800-848-0298) पर कॉल करें।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-558-6213 (телетайп: 1-800-848-0298).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. 1-800-558-6213 (TTY: 1-800-848-0298) تماس بگیرید.

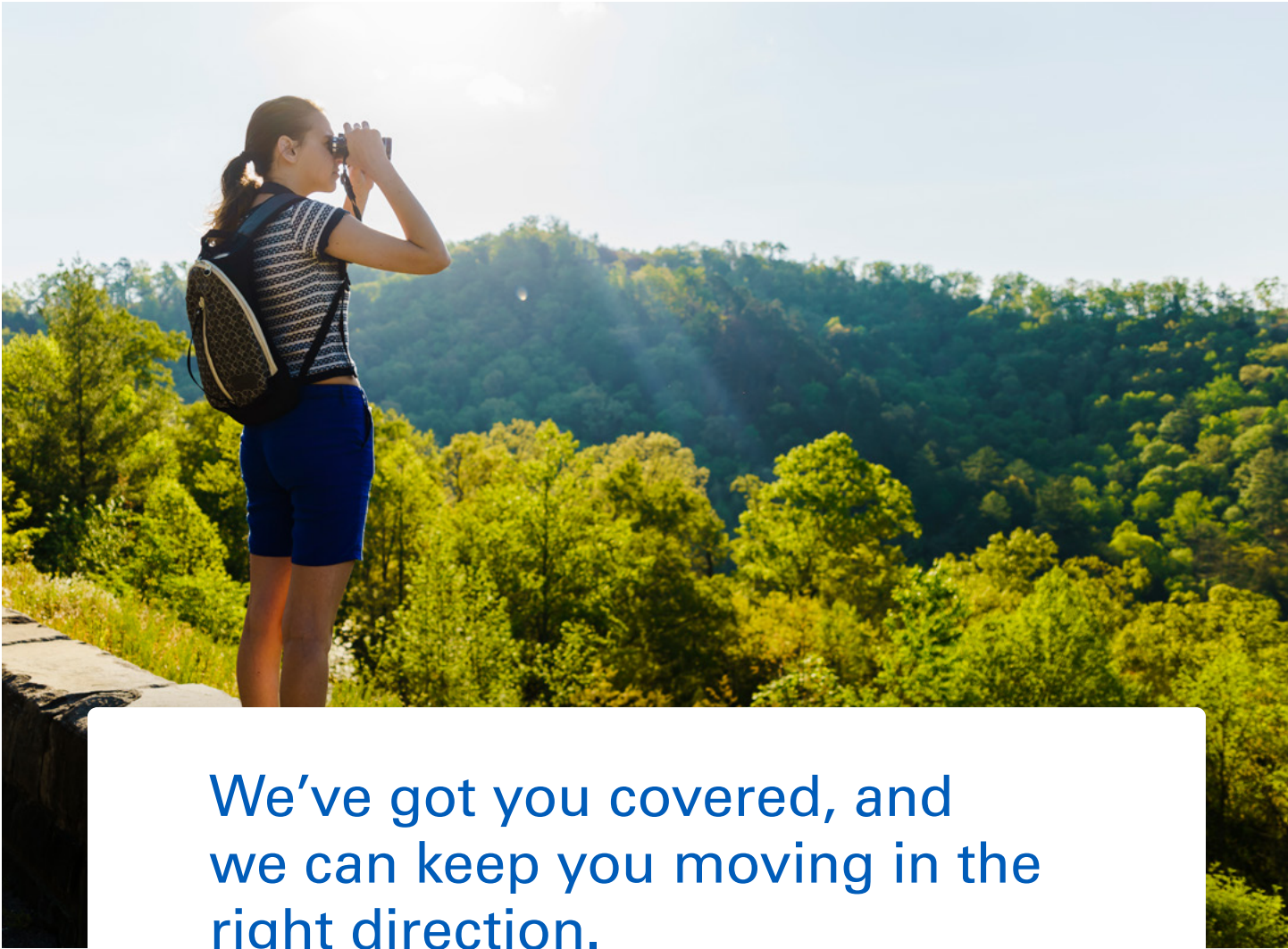
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-558-6213 (TTY: 1-800-848-0298).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 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).

ATTENZIONE: 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).

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánida'áwo'déé', t'áá jiik'eh, éi ná hółq, kojí' hódíilnih 1-800-558-6213 (TTY: 1-800-848-0298).



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