

Blue Network S
Member Handbook



**ACCESSTN
MEMBER HANDBOOK
EFFECTIVE JANUARY 1, 2010**

NOTICE

PLEASE READ THIS MEMBER HANDBOOK CAREFULLY AND KEEP IT IN A SAFE PLACE FOR FUTURE REFERENCE. IT EXPLAINS YOUR COVERAGE THROUGH ACCESSTN. IF YOU HAVE ANY QUESTIONS ABOUT THIS COVERAGE, PLEASE WRITE OR CALL US AT:

**ACCESSTN MEMBER SERVICE DEPARTMENT
BLUECROSS BLUESHIELD OF TENNESSEE, INC., ADMINISTRATOR
1 CAMERON HILL CIRCLE
CHATTANOOGA, TENNESSEE 37402-2555
(866) 636-0080
(866) 591-2908 TTY/TDD**

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INTRODUCTION

This Member Handbook describes the terms and conditions of Your Coverage. "You", "Your" and "Member" mean the person eligible and enrolled for benefits under the AccessTN program ("Plan"). "We", "Us" and "Our" mean the AccessTN Plan as administered by BlueCross BlueShield of Tennessee, Inc. (BCBST), the Plan Administrator. "Coverage" means the benefits Members are entitled to under this Plan.

PLEASE READ THIS MEMBER HANDBOOK CAREFULLY. IT DESCRIBES YOUR RIGHTS AND DUTIES AS A MEMBER. IT IS IMPORTANT TO READ THE ENTIRE HANDBOOK. CERTAIN SERVICES ARE NOT COVERED. OTHER COVERED SERVICES ARE LIMITED. THE PLAN DOES NOT PAY FOR ANY SERVICE NOT SPECIFICALLY LISTED AS A COVERED SERVICE, EVEN IF A HEALTH CARE PROVIDER RECOMMENDS OR ORDERS THAT NON-COVERED SERVICE (SEE ATTACHMENTS A-C.)

ANY GRIEVANCE RELATED TO COVERAGE UNDER THIS PLAN WILL BE RESOLVED IN ACCORDANCE WITH THE "GRIEVANCE PROCEDURE" SECTION OF THIS MEMBER HANDBOOK.

To make it easier to read and understand this Handbook, defined words are Capitalized. Those words are defined in the "DEFINITIONS" section of this Handbook.

Please contact one of the Member service representatives, at the number listed on the membership ID card, if You have any questions when reading this Member Handbook.

RIGHT TO RECEIVE AND RELEASE INFORMATION

You authorize and consent to Our receipt, use and release of personal information for Yourself. This consent includes any and all medical records, obtained, used or released in connection with administration of the Plan, subject to applicable laws. Such consent is deemed given by Your signature on the Application. Additional consent may be required whenever You obtain Covered Services under this Plan. This authorization and consent remains in effect throughout the period You are Covered under this Plan. This consent survives the termination of the Coverage to the extent that such information or records relate to services rendered while You were covered under the Plan.

You may also be required to consent to the release of personally identifiable health information in connection with the administration of the Plan. Refer to the Application for Health Coverage You signed to become a Member and to the Notice of Privacy Practices which is included as an Attachment to this Member Handbook for additional detail.

INDEPENDENT LICENSEE OF THE BLUECROSS BLUESHIELD ASSOCIATION

BlueCross BlueShield of Tennessee, Inc. is an independent corporation operating under a license from the BlueCross BlueShield Association (the "Association.") That license permits BlueCross BlueShield of Tennessee, Inc. to use the Association's service marks within its assigned geographical location. BlueCross BlueShield of Tennessee, Inc. is not a joint venture, agent or representative of the Association nor any other independent licensee of the Association.

What is AccessTN?

AccessTN is a health Coverage program sponsored by the State of Tennessee for people who can't get other health coverage because of their medical conditions. When we say "Coverage," we mean health insurance and other health benefit plans. We'll use "Plan" as short for AccessTN, including those companies we use to administer services such as enrollment, claims payment, or premium assistance.

In these and other Plan papers, We'll use plural words like "We" or "Our" or "Us" to mean AccessTN. We'll use individual words like "You" for the Applicant, a person applying for Coverage. We may also use "Member" to refer to a person enrolled in AccessTN. When we say "health facts," we mean personal health information – your health history and other facts that identify You like Your name and date of birth.

Anytime We say that something is available at www.AccessTN.gov, You can also get that information by calling toll free to 1-866-636-0080, which is the customer service line for the AccessTN plan administrator, BlueCross BlueShield of Tennessee, Inc. Information is available on their website at www.bcbst.com. You can find AccessTN information under the Plan Options tab at the top of the page.

How does health coverage and health insurance work?

AccessTN is NOT TennCare, a medical assistance program regulated by federal Medicaid guidelines. It is not Medicare either. It is health Coverage similar to other types of health insurance.

Insurance is a contract arrangement in which You pay a set fee (a premium) to receive coverage for a set schedule of medical and health services (benefit plan). The premium is based on the Plan's professional estimate of what those services will cost. "Covered services" are simply those the Plan covers, or pays for.

This Member Handbook is our Plan document that describes the contractual arrangement between You and the Plan and describes the schedule of health services You have selected as Your benefit plan.

You should also understand that insurance will not pay for other services, called "non-covered services." If You have these services done, You will have to pay these claims yourself, even if a doctor prescribes them. That's why it's important to choose your benefit plan carefully and know what services We will and will not cover.

AccessTN has different choices of benefit plans. The schedule of benefits You have chosen is described in this Member Handbook. All benefit plans are subject to change by the AccessTN Board, upon the mailing of written notice to Members as described in this Member Handbook.

Our current options are all based on a PPO (preferred provider organization) design. This means that the Plan contracts with a "network" of doctors, hospitals and other health providers. They agree to be paid a set amount for each covered service. They will not collect more from you than a pre-set share of the claim, called "Co-insurance." This Member share is frequently 20% in our benefit plans.

Services from "Out-of-Network" providers have a higher Member share, frequently 40%. Those Out-of-Network providers can also charge you more than the Plan's "Maximum Allowable Charge" (MAC). If You use an Out-of-Network Provider, You are also responsible for the difference between Billed Charges and the Maximum Allowable Charge for a Covered Service. Look at the provider directory on www.bcbst.com or call 1-866-636-0080 to see if Your current doctors are "Network Providers."

In some cases, as is described in this Member Handbook, Your physician is required to have services pre-authorized to receive full reimbursement. Your Network Providers are responsible for securing this authorization, and Your cost will not be affected.

However, You should be aware that Out-of-Network providers or out-of-state providers are not required to seek these plan required approvals, and that you must make sure such Prior Authorizations are obtained, or your member cost share, such as Coinsurance, will be increased for non-authorized services.

RELATIONSHIP BETWEEN ACCESSTN AND PLAN ADMINISTRATOR

BlueCross and BlueShield of Tennessee, Inc. (BCBST) has contracted to perform administrative services for the State of Tennessee, AccessTN Board of Directors (AccessTN Board or Board), and the Department of Finance and Administration of the State of Tennessee. Such services include network contracting, customer service, claims payment, eligibility determination, and utilization review and clinical management. AccessTN will also be using the BCBST contracted provider networks for AccessTN.

In addition to the Plan Administrator, AccessTN may have other contractors provide additional administrative services for the Plan. These contractors will perform services in a manner consistent with this Member Handbook.

RELATIONSHIP WITH NETWORK PROVIDERS

A. Independent Contractors

Network Providers contract with Us and We have agreed to pay them for rendering Covered Services to Members. Network Providers are solely responsible for making all medical treatment decisions with their member-patients. We do not make medical treatment decisions under any circumstances. Our decisions are limited to deciding what services are considered Covered Services under Your benefit Plan. Network Providers are not Our employees, agents or representatives.

We have the discretionary authority to make benefit or eligibility determinations and interpret the terms of Coverage under this Plan (“Coverage Decisions.”) We make those Coverage Decisions based on the terms of this Plan, Our benefit policies, other relevant sources of information, Our participation agreements with Network Providers and applicable State or Federal laws.

We have participation agreements with the Network Providers. These permit Network Providers to dispute Our Coverage decisions if they disagree with those decisions. If the Network Provider does not dispute a Coverage Decision, the Member may request reconsideration of the Coverage Decision as explained in the Grievance Procedure section of this Handbook. The participation agreement requires Network Providers to fully and fairly explain Coverage decisions to Members, upon request, if the Member decides to request that We reconsider a Coverage Decision.

We have various incentive arrangements to encourage Network Providers to provide Covered Services to Members in an appropriate and cost effective manner. You may request information about Your Provider’s payment arrangement by contacting Our Member service department.

B. Termination of Providers’ Participation

A Network Provider or We may end our relationship with each other at any time. A Network Provider may also limit the number of Members that he, she or it will accept as patients during the term of this Plan. We do not promise that any specific Network Provider will be available to render services while You are Covered by this Plan.

ELIGIBILITY

If You are eligible for this Plan according to eligibility categories determined by the Access Tennessee Board, You can enroll. If there is a question about eligibility, the policies of the Access Tennessee Board will control Our final decision. The State's guidelines on eligibility may be found at:

http://www.covertn.gov/web/access_eligible.html

ENROLLMENT AND CHANGES IN ELIGIBILITY

If You have or later get access to other health coverage through Your employer or enroll thereafter in other individual or group health coverage, TennCare or Medicare, You must notify Us at 1-866-636-0080. If You enroll in AccessTN and later terminate Your AccessTN Coverage, such action shall disqualify you for eligibility for AccessTN for one year from such termination, except for such exceptions as may be set by Board policy.

The AccessTN Board may modify eligibility requirements from time to time. Please look at www.accesstn.gov or call 1-866-636-0080 if You need additional information.

ENROLLMENT

AccessTN will have a limited number of spaces available in the Plan, according to the Board's determination of the number of people whose Plan benefits We can fund. The AccessTN Board may also set different eligibility categories as permitted by Tennessee law and will set the criteria for each eligibility category. If You are eligible, You may apply to enroll for Individual Coverage. There is no dependent coverage in AccessTN.

1. Complete an Application.
2. Submit the completed and signed Application to Us.
3. We will notify You if You qualify and if there is space in the eligibility category to which You are applying.
4. We will bill You for the required Premium when the Premium is due.

A. Change of Plans – Plan Re-enrollment Period

After You review Your AccessTN Member Handbook, You may decide another benefit plan may better suit Your needs. You may request to change plans during the first 30 days of Your Coverage. After that time, You may only change to any other AccessTN plan during the annual Plan Re-enrollment Period. The annual Plan Re-enrollment Period for AccessTN is from November 1 through November 30 of each year. You must notify Us of Your wish to change Plans. The change will be effective January 1 of the next Plan year.

B. Notification of Change in Status after Enrollment

You must submit a Change Form to Us if any changes occur in Your status, within 31 days from the date of the event causing that change. Such events include, but are not limited to: (1) enrollment in TennCare or any other State Medicaid Program;(2) enrollment in Medicare; or (3) coverage by another Payor. These are also called Qualifying Events. You must also submit an Application Change Form to Us if You have a change of name or address. This is not a Qualifying Event. In the event of Your death, a representative should notify Us.

EFFECTIVE DATE OF COVERAGE

If You are eligible and have applied, and have paid the initial Premium, We will notify You of Your Effective Date.

PREMIUMS

You must pay the Premiums due for Your Coverage in full on or before the due date. Premiums must be received by Us.

A. Premium Due Date

The Premium due date is stated on Your approval letter. Your Premium is due at the beginning of the coverage month. The term of Your Coverage is the same as Your Premium payment period.

For example, You pay Your Premiums monthly, Your Coverage term is for one month, and it automatically renews when You pay Your Premium.

B. Premium Refund

After payment of Your Premium, the Premium for that month is non-refundable. Partial or pro-rata coverage for part of a month is not permitted.

C. Right to Change Premium

The Plan may change Your Premium, or rate basis, on:

1. Any Premium due date. You will be notified at least 30 days before the change;
or
2. Any date the terms of the Coverage are changed.

D. Other Premium Changes

Your Premium may change automatically in the following circumstances, on the next date Your Premium is due:

1. If Your benefits increase or decrease;
2. As You age, Your Premium rate can change at certain ages.

TERMINATION OF COVERAGE

A. Termination of Coverage

Your Coverage is guaranteed renewable, until the first of the following occurs:

1. We do not receive the required Premium for Your Coverage when it is due; or
2. You request to terminate the Coverage and give Us advance written notice. Termination will take place the first day of the month following Our receipt of such notice; or
3. You move outside of Tennessee; or
4. You have made a material misrepresentation or committed fraud against Us. This provision includes, but is not limited to, furnishing incorrect or misleading information or permitting the improper use of Your membership card; or
5. You become eligible for Medicare; or
6. The AccessTN Plan or Your eligibility category is reduced or discontinued; or
7. You have access to other coverage, as defined by AccessTN, whether or not You enroll for such coverage.

Upon notice to Us that You have enrolled in group or other coverage, Your AccessTN coverage may continue as a secondary coverage until the expiration of any Pre-existing Condition Waiting Period on the other coverage.

For example, if you go to work for an employer that offers group coverage for which you may enroll without a Pre-existing Condition Waiting Period, Your eligibility for coverage under AccessTN will end upon your eligibility for the group coverage. If the group coverage contains a 6-month or other Pre-existing Condition Waiting Period which applies to You, Your AccessTN Coverage may continue, on a secondary basis, until the end of such Pre-existing Condition Waiting Period.

B. Termination by AccessTN Board

Enrollment in the Plan does not create an unqualified right to continued eligibility for Coverage under AccessTN. All enrollment is subject to limitations in the number of persons in each AccessTN eligibility category. All eligibility category criteria and capacity are subject to change by AccessTN Board in a manner consistent with Tennessee law and as supported by available funding. The AccessTN Board may change the criteria for eligibility or the number of available spaces. The Plan, will mail a notice to you at your address of record with AccessTN at least 30 days prior to any change in the enrollment criteria for your eligibility category or termination.

C. Grace Period

You have a 31-day Grace Period in which to pay your Premium. A Grace Period is a specific time after Your Premium is due, during which You can pay Your Premium, without a lapse in Coverage.

If You pay the Premium during the Grace Period, Your Coverage will continue and claims for Covered Services incurred during the Grace Period will be honored.

If You do not pay the Premium due, in full, by the due date or during the Grace Period, Your Coverage will terminate retroactive to the last date for which Your premium is paid. We may suspend payments to Providers rendering services to You during the Grace Period. You will be liable for Providers' charges for services rendered during the Grace Period.

D. Payment For Services Rendered After Termination of Coverage

If You receive and We pay for Covered Services after the termination of Your Coverage, We may recover the Amount Paid for such Covered Services from You, plus any costs of recovering such payments, including Our attorneys' fees.

E. Reinstatement

If Your Coverage terminates, You must wait 12 months to apply for new Coverage under AccessTN.

F. Right To File a Grievance

You may file a grievance to appeal the termination of Your membership for cause, as explained in the "Grievance Procedure" section of this Member Handbook. The fact that You have filed a grievance does not postpone or prevent Us from terminating or otherwise modifying Your Coverage as permitted by this Member Handbook or AccessTN policies. If Your Coverage is reinstated following that hearing, You may submit any claims for Covered Services rendered after Your Coverage was terminated to Us for consideration, in accordance with the "Claims Procedure" section of this Member Handbook.

CLAIMS AND PAYMENT

When You receive Covered Services, either You or the Provider must submit a claim form to Us. We will review the claim, and let You, or the Provider, know if We need more information, before We pay or deny the claim. We follow our internal administration procedures when We adjudicate claims.

A. Claims.

There are several terms to describe a claim: pre-service claim; post-service claim; and a claim for Urgent Care.

1. A pre-service claim is any claim that requires approval of a Covered Service in advance of obtaining medical care as a condition of receipt of a Covered Service, in whole or in part.
2. A post-service claim is a claim for a Covered Service that is not a pre-service claim – the medical care has already been provided to the Member. Only post-service claims can be billed to You or Us.
3. Urgent Care is medical care or treatment that, if delayed or denied, could seriously jeopardize: (1) the life or health of the claimant; or (2) the claimant's ability to regain maximum function. Urgent Care is also medical care or treatment that, if delayed or denied, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the medical care or treatment. A claim for denied Urgent Care is always a pre-service claim.

B. Claims Billing.

1. You should not be billed or charged for Covered Services rendered by Network Providers, except for required Member payments. The Network Provider will submit the claim directly to Us.
2. You may be charged or billed by an Out-of-Network Provider for Covered Services rendered by that Provider. If You use an Out-of-Network Provider, You are responsible for the difference between Billed Charges and the Maximum Allowable Charge for a Covered Service. You are also responsible for complying with any of Our Medical Policy and Medical Management procedures (including, obtaining Prior Authorization of such Services, when necessary).
 - a. If You are charged, or receive a bill, You must submit a claim to Us.
 - b. To be reimbursed, You must submit the claim within 1 year and 90 days from the date a Covered Service was received. If You do not submit a claim, within the 1 year and 90 day time period, it will not be paid.
 - c. If it is not reasonably possible to submit the claim within the 1 year and 90 day time period, the claim will not be invalidated or reduced.
3. Not all Covered Services are available from Network Providers. There may be some Provider types with which We do not contract. These Providers are called Non-Contracted Providers. Claims for services received from Non-Contracted Providers are handled in the same manner as described above for Out-of-Network Providers. You also have the same responsibilities as described above.
4. You may request a claim form from Our Member service department. We will send You a claim form within 2 business days. You must submit proof of

payment acceptable to Us with the claim form. We may also request additional information or documentation if it is reasonably necessary to make a Coverage decision concerning a claim.

5. A Network Provider, or an Out-of-Network Provider may refuse to render, or reduce or terminate a service that has been rendered, or require You to pay for what You believe should be a Covered Service. If this occurs:
 - a. You may submit a claim to Us to obtain a Coverage decision concerning whether the Plan will Cover that service. For example, if a pharmacy (1) does not provide You with a prescribed medication; or (2) requires You to pay for that prescription, You may submit a claim to Us to obtain a Coverage decision about whether it is Covered by the Plan.
 - b. You may request a claim form from Our Member service department. We will send You a claim form within 2 business days. We may request additional information or documentation if it is reasonably necessary to make a Coverage decision concerning a claim.

C. Payment

1. If You received Covered Services from a Network Provider, We will pay the Network Provider directly. These payments are made according to Our agreement with that Network Provider. You authorize assignment of benefits to that Network Provider. Covered Services will be paid at the Network Benefit level.
2. Out-of-Network Providers may or may not file claims for You. A completed claim form for Covered Services must be submitted in a timely manner. We will reimburse You, unless You have assigned benefits to the Provider. You will be responsible for the difference in the Billed Charge and the Maximum Allowable Charge for that Covered Service. Our payment fully discharges Our obligation related to that claim.
3. Non-Contracted Providers may or may not file Your claims for You. Either way, the Network Benefit level shown in Attachment C will apply to claims for Covered Services received from Non-Contracted Providers. However, You will be responsible for the difference in the Billed Charge and the Maximum Allowable Charge for that Covered Service. Our payment fully discharges Our obligation related to that claim.
4. If this Coverage is terminated, all claims for Covered Services rendered prior to the termination date, must be submitted to Us within 1 year and 90 days from the date the Covered Services were received.
5. We will pay benefits within 30 days after We receive a claim form that is complete. Claims are processed in accordance with current industry practices, and based on Our information at the time We receive the claim form. We are not responsible for over or under payment of claims if Our information is not complete or is inaccurate. We will make reasonable efforts to obtain and verify relevant facts when claim forms are submitted. Payment for Covered Services is more fully described in Attachment C.

D. Assignment

If You assign payment for a claim to a Provider, We must honor that assignment. If You have paid the Provider, and also assigned payment for the claim to the Provider, You must request repayment from that Provider.

E. Complete Information

Whenever You need to file a claim for Yourself, We can process it more efficiently if You complete a claim form. This will ensure that You provide all the information needed. Most Providers will have claim forms or You can request them from Us by calling Our Member service department at the number listed on Your membership ID card.

Mail all claim forms to:

BCBST Claims Service Center
1 Cameron Hill Circle Suite 0002
Chattanooga, Tennessee 37402-0002

BLUECARD PPO PROGRAM

When You are in an area where BCBST Network Providers are not available and You need health care services or information about a BlueCross BlueShield PPO physician or hospital, just call the BlueCard PPO Doctor and Hospital Information Line at 1-800-810-BLUE (2583.)

We will help You locate the nearest BlueCard PPO Participating Provider.

In the BlueCard PPO Program, the term, "Host Plan" means the BlueCross BlueShield Plan that provides access to service in the location where You need health care services.

Show Your membership ID card (that has the "PPO in a suitcase" logo) to any BlueCard PPO Participating Provider. The BlueCard PPO Participating Provider can verify Your eligibility and Coverage with Your BlueCross BlueShield Plan. When You visit a BlueCard PPO Participating Provider, You should not have claim forms to file. After You receive services, Your claim is electronically routed to BCBST, which processes it and sends You a detailed explanation of benefits. You are responsible for any applicable Copayments, or Your Deductible and Coinsurance payments (if any.)

The calculation of Your liability for claims incurred outside the BCBST service area that are processed through the BlueCard PPO program will typically be at the lower of the Provider's Billed Charges or the negotiated price BCBST pays the Host Plan.

The negotiated price paid by BCBST to the Host Plan for health care services provided through the BlueCard PPO Program may represent either: (a) the actual price paid by the Host Plan on such claims; (b) an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the on-site Plan's health care Providers or one or more particular Providers; or (c) a discount from Billed Charges representing the on-site Plan's expected average savings for all of its Providers or for a specified group of Providers. The discount that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price.

Plans using either the estimated price or average savings factor methods may prospectively adjust the estimated or average price to correct for over- or underestimation of past prices. However, the amount You pay is considered a final price.

In addition, laws in certain states may require BlueCross and/or BlueShield Plans to use a basis for calculating Your liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Thus, if You receive Covered Services in these states, Your liability for Covered Services will be calculated using these states' statutory methods.

REMEMBER: YOU ARE RESPONSIBLE FOR RECEIVING PRIOR AUTHORIZATION FROM BCBST. IF PRIOR AUTHORIZATION IS NOT RECEIVED, YOUR BENEFITS MAY BE REDUCED OR DENIED. CALL THE TOLL FREE NUMBER ON YOUR MEMBERSHIP ID CARD FOR PRIOR AUTHORIZATION. IN CASE OF AN EMERGENCY, YOU SHOULD SEEK IMMEDIATE CARE FROM THE CLOSEST HEALTH CARE PROVIDER.

NOTE: BlueCard PPO Providers are outside the State of Tennessee and are considered Network Providers for benefit purposes.

PRIOR AUTHORIZATION, CARE MANAGEMENT, MEDICAL POLICY AND PATIENT SAFETY

BlueCross BlueShield of Tennessee provides services to help manage Your care including, performing Prior Authorization of certain services to ensure they are Medically Necessary, Concurrent Review of hospitalization, discharge planning, lifestyle and health counseling, low-risk case management, catastrophic medical and transplant case management and the development and publishing of medical policy.

BCBST does not make medical treatment decisions under any circumstances. You may always elect to receive services that do not comply with BCBST's Care Management requirements or medical policy, but doing so may affect the Coverage of such services.

Effective January 1, 2010, AccessTN members who meet certain criteria will be required to participate in the Disease Management/Care (Case) Management programs We offer. Enrollment in Disease Management/Care (Case) Management will become mandatory if you are identified as needing these services. By enrolling, you get extra support to improve your overall health and manage your current health issues.

Prior Authorization

BCBST must Authorize some Covered Services in advance in order for those Covered Services to be paid at the Maximum Allowable Charge without Penalty. Obtaining Prior Authorization is not a guarantee of Coverage. All provisions of the Member Handbook must be satisfied before Coverage for services will be provided.

Services that require Prior Authorization include, but are not limited to:

- Inpatient Hospital stays (except maternity admissions)
- Skilled nursing facility and rehabilitation facility admissions
- Certain Outpatient Surgeries and/or procedures
- Certain Specialty Drugs
- Certain Prescription Drugs (if Covered by a prescription drug card)
- Advanced Radiological Imaging services
- Durable Medical Equipment (DME) greater than \$500
- Initial purchase or replacement of artificial limbs
- Other services not listed at the time of printing may be added to the list of services that require Prior Authorization. Notice of changes to the Prior Authorization list will be made via Our Web site and the Member newsletter. You may also call Our customer service department at the phone number on Your ID card to find out which services require Prior Authorization.

Refer to Attachment C: Schedule of Benefits for details on benefit penalties for failure to obtain Prior Authorization.

Network Providers in Tennessee will request Prior Authorization for You.

You are responsible for requesting Prior Authorization when using Providers outside Tennessee and Out-of-Network Providers, or benefits will be reduced or denied.

For the most current list of services that require Prior Authorization, call customer service or visit our Web site at www.bcbst.com.

BCBST may authorize some services for a limited time. BCBST must review any request for additional days or services.

Network Providers in Tennessee are required to comply with all of BCBST's medical management programs. You are held harmless (not responsible for Penalties) if a Network Provider in Tennessee fails to comply with Care Management program and Prior Authorization requirements, unless You agreed that the Provider should not comply with such requirements.

The Member is not held harmless if:

- a. A Network Provider outside Tennessee (known as a BlueCard PPO Participating Provider) fails to comply with Care Management program and Prior Authorization requirements, or
- b. An Out-of-Network Provider fails to comply with Care Management program and Prior Authorization requirements.

If You use an Out-of-Network Provider, or a Provider outside Tennessee, such as a Blue Card PPO Participating Provider, You are responsible for ensuring that the Provider obtains the appropriate Authorization prior to treatment. Failure to obtain the necessary Authorization may result in additional Member Payments and reduced Plan payment. Contact Our customer service department for a list of Covered Services that require Prior Authorization.

Care Management

A number of Care Management programs are available to Members, including those with low-risk health conditions, potentially complicated medical needs, chronic illness and/or catastrophic illnesses or injuries.

Lifestyle and Health Education -- Lifestyle and health education is for healthy Members and those with low-risk health conditions that can be self-managed with educational materials and tools. The program includes: (1) wellness, lifestyle, and condition-specific educational materials; (2) an on-line resource for researching health topics; and (3) a toll-free number for obtaining information on more than 1,200 health-related topics.

Low Risk Case Management -- Low risk case management, including disease management, is performed for Members with conditions that require a daily regimen of care. Registered nurses work with health care Providers, the Member, and primary care givers to coordinate care. Specific programs include: (1) pharmacy Care Management for special populations; (2) Emergency services management program; (3) transition of care program; (4) condition-specific care coordination program; and (5) disease management.

Catastrophic Medical and Transplant Case Management -- Members with terminal illness, severe injury, major trauma, cognitive or physical disability, or Members who are transplant candidates may be served by the catastrophic medical and transplant case management program. Registered nurses work with health care Providers, the Member, and primary caregivers to coordinate the most appropriate, cost-efficient care settings. Case managers maintain regular contact with Members throughout treatment, coordinate clinical and health plan Coverage issues, and help families utilize available community resources.

After evaluation of the Member's condition, it may be determined that alternative treatment is Medically Necessary and Appropriate.

In that event, alternative benefits for services not otherwise specified as Covered Services in Attachment A may be offered to the Member. Such benefits shall not exceed the Lifetime Maximum specified or the total amount of benefits under this Member Handbook, and will be

offered only in accordance with a written case management or alternative treatment plan agreed to by the Member's attending physician and BCBST.

Emerging Health Care Programs -- Care Management is continually evaluating emerging health care programs. These are services or technologies that demonstrate reasonable potential improvement in access, quality, health care costs, efficiency, and Member satisfaction. When We approve an emerging health care program, services provided through that program are Covered, even though they may normally be excluded under the Member Handbook.

Care Management services, emerging health care programs and alternative treatment plans may be offered to eligible Members on a case-by-case basis to address their unique needs. Under no circumstances does a Member acquire a vested interest in continued receipt of a particular level of benefits. Offer or confirmation of Care Management services, emerging health care programs or alternative treatment plans to address a Member's unique needs in one instance shall not obligate the Plan to provide the same or similar benefits for any other Member.

Medical Policy

Medical Policy looks at the value of new and current medical science. Its goal is to make sure that Covered Services have proven medical value.

Medical policies are based on an evidence-based research process that seeks to determine the scientific merit of a particular medical technology. Determinations with respect to technologies are made using technology evaluation criteria. "Technologies" means devices, procedures, medications and other emerging medical services.

Medical policies state whether or not a technology is Medically Necessary, Investigational or cosmetic. As technologies change and improve, and as Members' needs change, We may reevaluate and change medical policies without formal notice. You may check Our medical policies at www.bcbst.com. Enter "medical policy" in the Search field. BCBST's Medical Policies are made a part of this Member Handbook by reference.

Medical policies sometimes define certain terms. If the definition of a term defined in a medical policy differs from a definition in this Member Handbook, the medical policy definition controls.

Patient Safety

If You have a concern with the safety or quality of care You received from a Network Provider, please call Us at the number on the membership ID card. Your concern will be noted and investigated by Our Clinical Risk Management department.

SUBROGATION OR RIGHT OF RECOVERY

You agree that We shall be subrogated to and/or have the right to recover amounts paid to provide Covered Services to You for illnesses or injuries caused by third parties, including the right to recover the reasonable value of prepaid services rendered by Network Providers.

We shall have first lien against any payment, judgment or settlement of any kind that You receive from or on behalf of such third parties for medical expenses, for the costs of Covered Services and any costs of recovering such amounts from those third parties. We may notify those parties of Our lien without notice to or consent from You.

Without limitation, We may enforce Our rights of subrogation and recovery against any tortfeasors, other responsible third parties or against available insurance coverages, including: underinsured or uninsured motorist coverages; liability insurance, including general liability insurance and automobile liability insurance; automobile medical payment insurance; workers' compensation; or similar insurance.

Such actions may be based in tort, contract or other cause of action to the fullest extent permitted by law.

To enable Us to protect Our rights under this section, You are required to notify Us promptly if an illness or injury is caused by a third party or is covered by other available insurance coverage. You are also required to cooperate with Us and to execute any documents that We deem necessary to protect Our rights under this section. If You settle any claim or action without Our consent against any third party, You shall be deemed to have been made whole by the settlement, and We shall be entitled to immediately collect the present value of Our rights as a first priority claim from the settlement fund. Any such proceeds of settlement or judgment shall be held in trust by You for Our benefit. We shall also be entitled to recover reasonable attorneys' fees incurred in collecting proceeds held by You in such circumstances.

GRIEVANCE PROCEDURE

A. INTRODUCTION

Our Grievance procedure (the "Procedure") is intended to provide You with a fair, quick and inexpensive method of resolving any and all Disputes with Us. Such Disputes include: any matters that cause You to be dissatisfied with any aspect of Your relationship with Us; any Adverse Benefit Determination concerning a Claim; or any other claim, controversy, or potential cause of action You may have against Us. Please contact the Member service department, at the number listed on Your membership ID card: (1) to file a Claim; (2) if You have any questions about this Plan or other documents that You receive from Us (e.g. an explanation of benefits); or (3) to initiate a Grievance concerning a Dispute.

This Procedure is the exclusive method of resolving any Dispute. Exemplary or punitive damages are not available in any Grievance, arbitration, or litigation action, pursuant to the terms of this Coverage. Any decision to award damages must be based upon the terms of this Coverage.

The Procedure can only resolve Disputes that are subject to Our control.

You cannot use this Procedure to resolve a claim that a Provider was negligent. Network Providers are independent contractors. They are solely responsible for making treatment decisions in consultation with their patients. You may contact Us; however, to complain about any matter related to the quality or availability of services, or any other aspect of Your relationship with Providers.

An Adverse Benefit Determination is any denial, reduction, termination or failure to provide or make payment for what You believe should be a Covered Service.

If a Provider does not render, or reduces or terminates a service that has been rendered, or requires You to pay for what You believe should be a Covered Service, You may submit a Claim to Us to obtain a determination concerning whether the Plan will cover that service. As an example, if a pharmacy does not provide You with a prescribed medication or requires You to pay for that prescription, You may submit a Claim to Us to obtain a determination about whether it is Covered by the Plan. Providers may be required to hold You harmless for the cost of services in some circumstances.

Providers may also appeal an Adverse Benefit Determination through Our Commercial Provider dispute resolution procedure.

Our determination will not be an Adverse Benefit Determination if: (1) a Provider is required to hold You harmless for the cost of services rendered; or (2) until We have rendered a final Adverse Benefit Determination in a matter being appealed through the Provider dispute resolution procedure.

You may request a form from Us to authorize another person to act on Your behalf concerning a Dispute.

You and We may agree to skip one or more of the steps of this Procedure if it will not help to resolve Our Dispute.

Any Dispute will be resolved in accordance with applicable Tennessee or Federal laws and regulations, and this Member Handbook.

Note: The **GRIEVANCE REVIEW PROCEDURES** section pertains to Grievances involving Benefits, Claims, Eligibility, etc. See:

- section **C. PREMIUM ASSISTANCE REVIEW PROCEDURES** for Grievances pertaining to Premium Assistance; and
- section **D. MEDICAL UNDERWRITING REVIEW PROCEDURES** for Grievances pertaining to Medical Underwriting.

B. GRIEVANCE REVIEW PROCEDURES

1. Inquiry

An Inquiry is an informal process that may answer questions or resolve a potential Dispute. You should contact a Member service representative if You have any questions about how to file a Claim or to attempt to resolve any Dispute. Making an Inquiry does not stop the time period for filing a Claim or beginning a Dispute. You do not have to make an Inquiry before filing a Grievance.

2. Grievance

You must submit a written request asking Us to reconsider an Adverse Benefit Determination, or take a requested action to resolve another type of Dispute (Your "Grievance"). You must begin the Dispute process within 180 days from the date We issue notice of an Adverse Benefit Determination or from the date of the event that is otherwise causing You to be dissatisfied with Us. If You do not initiate a Grievance within 180 days You may give up the right to take any action related to that Dispute.

Contact the Member service department at the number listed on Your membership ID card for assistance in preparing and submitting Your Grievance. They can provide You with the appropriate form to use in submitting a Grievance. This is the first level Grievance procedure.

3. First Level Grievance Hearing

After We have received and reviewed Your Grievance, Our first level Grievance committee will meet to consider Your Grievance and any additional information that You or others submit concerning that Grievance. In Grievances concerning urgent care or pre-service Claims, We will appoint one or more qualified reviewer(s) to consider such Grievances. Individuals involved in making prior determinations concerning Your Dispute are not eligible to be voting members of the first level Grievance committee or reviewers. The Committee or reviewers have full discretionary authority to make benefit and/or claim determinations, pursuant to the Plan.

4. First Level Written Decision

The committee or reviewers will consider the information presented, and the chairperson will send You a written decision concerning Your Grievance as follows:

- a. For a pre-service claim, within 30 days of receipt of Your request for review;
- b. For a post-service claim, within 60 days of receipt of Your request for review; and
- c. For a pre-service, urgent care claim, within 72 hours of receipt of Your request for review.

The decision of the Committee will be sent to You in writing and will contain:

- a. A statement of the committee's understanding of Your Grievance;
- b. The basis of the committee's decision; and
- c. Reference to the documentation or information upon which the committee based its decision. We will send You a copy of such documentation or information, without charge, upon written request.

5. Second Level Grievance Procedure

If You are not satisfied, You may file a written request for reconsideration within ninety (90) days after We issue the first level Grievance committee's decision. This is called a second level Grievance.

Your decision concerning whether to file a second level Grievance has no effect on Your rights to any other benefits under the Plan. Any person involved in making a decision concerning Your Dispute (e.g. first level committee members) will not be a voting member of the second level Grievance committee.

6. Second Level Grievance Hearing

You may request an in-person, video or telephonic hearing before the second level Grievance committee. You may also request that the second level Grievance committee reconsider the decision of the first level committee, even if You do not want to participate in a hearing concerning Your Grievance. If You wish to participate, Our representatives will promptly contact You to explain the hearing process and schedule the date, time and place for that hearing.

In either case, the second level committee will meet and consider all relevant information presented about Your Grievance, including:

- a. Any new, relevant information that You submit for consideration; and
- b. Information presented during the hearing. Second level Grievance committee members and You will be permitted to question each other and any witnesses during the hearing. You will also be permitted to make a closing statement to the committee at the end of the hearing.

7. Second Level Written Decision

After the hearing, the second level committee will meet in closed session to make a decision concerning Your Grievance. That decision will be sent to You in writing. The written decision will contain:

- a. A statement of the second level committee's understanding of Your Grievance;
- b. The basis of the second level committee's decision; and Reference to the documentation or information upon which the second level committee based its decision. Upon written request, We will send You a copy of any such documentation or information, without charge.

C.

C. C. PREMIUM ASSISTANCE REVIEW PROCEDURES

1. Inquiry

An Inquiry is an informal process that may answer questions or resolve a potential Dispute. You should contact Our Member service department at 1-866-636-0080 or the premium assistance administrator if You have questions or to discuss any premium assistance dispute. Making an Inquiry does not stop the time period for beginning the Dispute process. You do not have to make an Inquiry before filing a Grievance.

2. Grievance

You must submit a written request asking for reconsideration of an unfavorable premium assistance determination. You must begin the Dispute process within 180 days from the unfavorable determination notice or from the date of the event that is otherwise causing You to be dissatisfied. If You do not initiate a Grievance within 180 days of an unfavorable determination, You may give up the right to take any action related to that Dispute.

Contact the Member service department at 1-866-636-0080 for assistance in preparing and submitting Your Grievance. They can provide You with the appropriate form to use in submitting a Grievance.

3. First Level Grievance Review

After your Grievance is received, it will be forwarded to the State of Tennessee for review. The Benefits Administration in the Department of Finance and Administration for the State of Tennessee will handle Your grievance. Benefits Administration will send notification when a determination has been made. If you receive an unfavorable determination regarding your Grievance, you may submit a written request for additional review.

4. Second Level Grievance Review

The State of Tennessee has a review process that is available to you AFTER you have completed the first level Grievance process. To request further review of a premium assistance denial, follow the instructions provided in your Grievance determination letter or contact the Member service department at 1-866-636-0080. They can assist you in preparing and submitting a request for further review. After your request is received, it will be forwarded to Benefits Administration in the Department of Finance and Administration. Individuals involved in making prior determinations concerning Your Dispute are not eligible to be voting members of the Second Level Grievance Review. Benefits Administration will send notification regarding the outcome of the review.

D. D. MEDICAL UNDERWRITING REVIEW PROCEDURES

1. Inquiry

An Inquiry is an informal process that may answer questions or resolve a potential Dispute. You should contact Our Member service department at 1-866-636-0080 or the medical underwriting contractor if You have questions or to discuss any medical underwriting Dispute. Making an Inquiry does not stop the time period for beginning the Dispute process. You do not have to make an Inquiry before filing a Grievance.

2. Grievance

You must submit a written request asking for reconsideration of an unfavorable medical underwriting determination. You must begin the Dispute process within 180 days from the unfavorable determination notice or from the date of the event that is otherwise causing You to be dissatisfied. If You do not initiate a Grievance within 180 days of an unfavorable determination, You may give up the right to take any action related to that Dispute.

Contact the Member service department at 1-866-636-0080 for assistance in preparing and submitting Your Grievance. They can provide You with the appropriate form to use in submitting a Grievance.

3. First Level Grievance Review

After your Grievance is received, it will be forwarded to the State of Tennessee for review. The Benefits Administration in the Department of Finance and Administration for the State of Tennessee will handle Your grievance. Benefits Administration will send notification when a determination has been made. If you receive an unfavorable determination regarding your Grievance, you may submit a written request for additional review.

4. Second Level Grievance Review

The State of Tennessee has a review process that is available to you AFTER you have completed the first level Grievance process of the medical underwriting decision. To request further review of a medical underwriting denial, follow the instructions provided in your first level Grievance determination letter or contact the Member Service department at 1-866-636-0080. They can assist you in preparing and submitting a request for further review. After your request is received, it will be forwarded to Benefits Administration in the Department of Finance and Administration. Benefits Administration will send notification regarding the outcome of the review.

GENERAL PROVISIONS

A. Applicable Law

The laws of Tennessee govern this Plan.

B. Notices

All notices required by this Plan must be in writing. Notices to Us should be addressed to:

BlueCross BlueShield of Tennessee, Inc.
1 Cameron Hill Circle
Chattanooga, TN 37402-2555

We will send notices to You at the most recent address in Our files.

C. Legal Action

You cannot bring legal action under this Coverage until 60 days after proof of loss has been furnished. You cannot bring legal action after 3 years after the time proof of loss is required.

D. Right to Request Information

We have the right to request any additional necessary information or records with respect to the administration of this Plan.

E. Coordination of Benefits

This Plan of Coverage is not subject to Tennessee's Coordination of Benefits Regulation.

Payments made by specific types of policies are not subject to Coordination of Benefits with Your Coverage:

1. Coverage for specified disease or illness only (e.g. cancer policies);
2. Hospital indemnity or other fixed indemnity insurance; or
3. Coverage for accident only or disability income insurance.

If You have other health coverage, subject to specific exceptions for policy types provided by federal or state law, or by the AccessTN Board, whether group or individual or Medicaid or Medicare, this Coverage will terminate. Other health coverage, whether major medical or limited benefit plans, except such limited benefits specified in federal regulations issued pursuant to HIPAA, shall be cause for termination.

In the event You become eligible for other coverage after enrolling in AccessTN, You can keep this Coverage only for the duration of any Pre-existing Condition Waiting Period in the other after-occurring coverage. In such case, and in any other major medical or other coverage types as may be permitted, this Coverage will always pay secondary.

In any event, liability under this Coverage shall be limited to the amount that would have been paid in the absence of other insurance. In any event in which this Coverage is coordinating with other coverage of a policy type specified by the

AccessTN Board for Coordination of Benefits, this Coverage will always pay secondary except as specified by AccessTN Board action regarding the other specified policy type. In the event of such Coordination of Benefits, the total liability of Your Coverage shall be limited to the amount that would have been paid in the absence of other insurance, less the payments made by the other primary coverage.

Note: Payments under Your Coverage will always be secondary to any other available coverage except those specified above. AccessTN shall have the right to recover any payments for your medical treatment for which a Third Party is financially responsible or which is payable under other coverage held by You, including but not limited to:

1. Liability insurance, including general liability insurance and automobile liability insurance;
2. Workers' compensation or similar insurance;
3. Automobile medical payment insurance

See the Subrogation section for additional information.

F. Administrative Errors

If We make an error in administering the benefits under this Plan, We may provide additional benefits or recover any overpayments from any person, insurance company, or plan. Any recovery must begin by the end of the calendar year following the year in which the claim was paid. This time limit does not apply if the Member did not provide complete information or if material misstatements or fraud have occurred. This time limit does not apply to recoveries from Network Providers.

No such error may be used to demand more benefits than those otherwise due under this Plan.

DEFINITIONS

Defined terms are Capitalized. When such defined words are used in this Member Handbook, they will have the meaning set forth in this section.

1. **Acute** - An illness or injury that is both severe and of short duration.
2. **Application** – A form that must be completed in full before You will be considered for Coverage.
3. **Application Change Form** – A form that must be completed to make a change in Your Coverage. Changes can include a change in Your level of coverage. This form is also used to make administrative changes, such as a change in name or address.
4. **Behavioral Health Services** - Any services or supplies that are Medically Necessary and Appropriate to treat: a mental or nervous condition; alcoholism; chemical dependence; drug abuse or drug addiction.
5. **Billed Charges** – The amount that a Provider charges for services rendered, based on the Provider's pricing prior to any contractual adjustments. Billed Charges may be different from the amount that We determine to be the Maximum Allowable Charge for services.
6. **BlueCard PPO Participating Provider** – A physician, Hospital, licensed skilled nursing facility, home health care Provider or other Provider who contracts with other BlueCross and/or BlueShield Association (Blue Card PPO) Plans and/or whom We have Authorized to provide Covered Services to Members.
7. **Calendar Year** - The period of time beginning at 12:01 A.M. on January 1st and ending 12:00 A.M. on the following December 31st.
8. **Care Management** – A program that promotes cost effective coordination of care for Members with complicated medical needs, chronic illnesses, and/or catastrophic illnesses or injuries.
9. **Coinsurance** - The amount, stated as a percentage of the Maximum Allowable Charge, which is Your responsibility during the Calendar Year, once the Deductible is satisfied. The Coinsurance percentage is calculated as 100%, minus the percentage payment of the Maximum Allowable Charge as specified in Attachment C.

In addition to the Coinsurance percentage, the Member is responsible for the difference between the Billed Charges and the Maximum Allowable Charge for Covered Services if the Billed Charges of a Non-Contracted Provider or an Out-of-Network Provider are more than the Maximum Allowable Charge for such Services.

For example, if the Out-of-Network Provider's Billed Charges are \$100 and the Maximum Allowable Charge for Network Providers is \$80, the Coinsurance percentage is based upon \$80, not \$100. In this example, the Member is responsible for the \$20 charge difference plus the Coinsurance percentage on the \$80 Maximum Allowable Charge.

10. **Complications of Pregnancy** – Conditions requiring Hospital Confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or caused by pregnancy, such as Acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, non-elective caesarean section,

ectopic pregnancy which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy does not include false labor; occasional spotting; physician prescribed rest during the period of pregnancy; morning sickness; hyperemesis gravidarum and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

11. **Concurrent Review Process** – The process of evaluating care during the period when Covered Services are being rendered.
12. **Contracted Transplant Institution** – A facility or hospital that has contracted with Us (or with an entity on Our behalf) to provide Transplant Services for some or all organ and bone marrow transplant procedures Covered under this Plan. For example, some hospitals might contract to perform heart transplants, but not liver transplants. A Contracted Transplant Institution is a Network Provider when performing contracted transplant procedures in accordance with the requirements of this Coverage.
13. **Copayment** – The dollar amount specified in Attachment C that the Member is required to pay directly to a Provider for certain Covered Services. The Member must pay such Copayments at the time he/she receives those Services.
14. **Cosmetic Surgery** – Any treatment intended to improve the Member's appearance. Our Medical Policy establishes the criteria for what is cosmetic and what is Medically Necessary and Appropriate.
15. **Covered Services, Coverage or Covered** - Those Medically Necessary and Appropriate services and supplies that are set forth in Attachment A of this Member Handbook. Covered Services are subject to all the terms, conditions, exclusions and limitations of this Member Handbook.
16. **Custodial Care** - Any services or supplies provided to assist an individual in the activities of daily living, as determined by Us. This includes, but not limited to eating, bathing, dressing or other self-care activities.
17. **Deductible** - The dollar amount, specified in Attachment C, that the Member must incur and pay for Covered Services during a Calendar Year before We provide benefits for services. There are two separate Deductible amounts – one for Network Providers and one for Out-of-Network Providers. The Deductible(s) will apply to the Individual Out-of-Pocket Maximum(s.)

Copayments and any balance of charges (between Billed Charges and the Maximum Allowable Charge) are not considered when determining if the Member has satisfied a Deductible.

18. **Emergency** – A sudden and unexpected medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect to result in:
 1. serious impairment of bodily functions; or
 2. serious dysfunction of any bodily organ or part; or
 3. placing the Member's health in serious jeopardy.

Examples of Emergency conditions include: (1) severe chest pain; (2) uncontrollable bleeding; or (3) unconsciousness.

19. **Emergency Care Services** - Those services and supplies that are Medically Necessary and Appropriate in the treatment of an Emergency.
20. **Hospital Confinement or Hospital Admission** – When the Member is treated as a registered bed patient at a Hospital or other Provider facility and incurs a room and board charge.
21. **Hospital Services** - Covered Services that are Medically Appropriate to be provided by an Acute care hospital.
22. **Individual Coverage** – Coverage just for You. It does not include Your Dependents.
23. **Investigational Services** - A drug, device, treatment, therapy, procedure, or other service or supply that does not meet the definition of Medical Necessity or:
 - a. cannot be lawfully marketed without the approval of the Food and Drug Administration (“FDA”) when such approval has not been granted at that time of its use or proposed use; or
 - b. is the subject of a current Investigational new drug or new device application on file with the FDA; or
 - c. is being provided according to a Phase I or Phase II clinical trial or the experimental or research portion of a Phase III clinical trial (provided, however, that participation in a clinical trial will not be the sole basis for the determination of Medical Necessity); or
 - d. is being provided according to a written protocol that describes among its objectives, determining the safety, toxicity, efficacy or effectiveness of that service or supply in comparison with conventional alternatives; or
 - e. is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (“IRB”) as required and defined by Federal regulations, particularly those of the FDA or the Department of Health and Human Services (“HHS”); or
 - f. in the predominant opinion of experts, as expressed in the published authoritative literature, that usage should be substantially confined to research settings; or
 - g. in the predominant opinion of experts, as expressed in the published authoritative literature, that further research is necessary in order to define safety, toxicity, efficacy, or effectiveness of that Service compared with conventional alternatives; or
 - h. the service or supply is required to treat a complication of an experimental or Investigational Service.

Our Medical Director has discretionary authority to make a determination concerning whether a service or supply is an Investigational Service. If Our Medical Director does not authorize the provision of a service or supply, it will not be a Covered Service. In making such determinations, Our Medical Director shall rely upon any or all of the following, at his or her discretion:

- a. The Member’s medical records; or
- b. the protocol(s) under which proposed service or supply is to be delivered; or

- c. any consent document that the Member has executed or will be asked to execute, in order to receive the proposed service or supply; or
 - d. the published authoritative medical or scientific literature regarding the proposed service or supply in connection with the treatment of injuries or illnesses such as those experienced by the Member; or
 - e. regulations and other official publications issued by the FDA and HHS; or
 - f. the opinions of any entities that contract with Us to assess and coordinate the treatment of Members requiring non-Investigational Services; or
 - g. the findings of the BlueCross and BlueShield Association Technology Evaluation Center or other similar qualified evaluation entities.
24. **Lifetime Maximum** – The maximum amount of benefits for Covered Services rendered to the Member during the Member’s lifetime while Covered under this Plan.
25. **Maintenance Care** – Skilled services including skilled nursing visits, skilled nursing facility care, physical therapy, occupational therapy and/or speech therapy for chronic, static or progressive medical conditions where the services: (1) fail to contribute toward cure; (2) fail to improve unassisted clinical function; (3) fail to significantly improve health; and (4) are indefinite or long-term in nature.
26. **Maximum Allowable Charge** – The amount that We, at Our sole discretion, have determined to be the maximum amount payable for a Covered Service. That determination will be based upon Our contract with a Network Provider or the amount payable based on Our fee schedule for the Covered Services rendered by Out-of-Network Providers.
27. **Medical Director** - The physician designated by Us, or that physician’s designee, who is responsible for the administration of Our Medical Policy and Medical Management programs, including its authorization program.
28. **Medically Appropriate** – Services that have been determined by Our Medical Director to be of value in the care of a specific Member. To be Medically Appropriate a service must:
- a. be Medically Necessary;
 - b. be used to diagnose or treat a Member’s condition caused by disease, injury or congenital malformation;
 - c. be consistent with current standards of good medical practice for the Member’s medical condition;
 - d. be provided in the most appropriate site and at the most appropriate level of service for the Member’s medical condition; and
 - e. on an ongoing basis, have a reasonable probability of:
 - (1) correcting a significant congenital malformation or disfigurement caused by disease or injury.
 - (2) preventing significant malformation or disease.
 - (3) substantially improving a life sustaining bodily function impaired by disease or injury.
 - f. not be provided solely to improve a Member’s condition beyond normal variations in individual development and aging including:
 - (1) comfort measures in the absence of disease or injury.
 - (2) Cosmetic Surgery.
 - g. not be for the sole convenience of the Provider, Member or Member’s family.

29. **Medically Necessary or Medical Necessity** – Services that have been determined by Us to be of proven value for use in the general population. To be Medically Necessary a service must:
- have final approval from the appropriate government regulatory bodies;
 - have scientific evidence permitting conclusions concerning the effect of the service on health outcomes;
 - improve the net health outcome;
 - be as beneficial as any established alternative;
 - demonstrate the improvement outside the Investigational setting; and
 - not be an Investigational Service.
30. **Medicare** – Title XVIII of the Social Security Act, as amended.
31. **Member, You, Your** - Any person enrolled for this Coverage under AccessTN.
32. **Member Payment** – The dollar amounts for Covered Services that You are responsible for as set forth in Attachment C, including Copayments, Deductibles, Coinsurance and Penalties.
33. **Network Benefit** – The payment level that applies to Covered Services received from a Network Provider. See Attachment C.
34. **Network Provider (also called In-Network Provider)** - A Provider who has contracted with Us to provide access to benefits to Members at specified rates. Such Providers may be referred to as Blue Card PPO Participating Providers, Participating Hospitals, Transplant Network, etc.
35. **Non-Contracted Provider**– A Provider that renders Covered Services to a Member, but is in a specialty category or type with which We have not contracted to provide those Covered Services. These Providers can change, as we contract with different Providers. A Provider's status as a Non-Contracted Provider, Network Provider, or Out-of-Network Provider can and does change. We reserve the right to change a Provider's status.
36. **Non-Routine Diagnostic Services** – Services such as CAT scans, MRI's, PET scans, nuclear medicine and other similar technologies.
37. **Out-of-Network Provider** – Any Provider who is an eligible Provider type but who does not hold a contract with Us to provide Covered Services.
38. **Out-of-Pocket Maximum** - The total dollar amount, as stated in Attachment C, that the Member must incur and pay for Covered Services during the Calendar Year, including Deductible and Coinsurance. There are separate Out-of-Pocket Maximums – one for services rendered by Network Providers, and one for services rendered by Out-of-Network Providers.

Copayments (including Pharmacy Copayments), Penalties, Coinsurance amounts on Behavioral Health Services and any balance of charges (the difference between Billed Charges and the Maximum Allowable Charge) required for Covered Services rendered by Out-of-Network Providers will not be considered when determining if the Out-of-Pocket Maximum has been satisfied.

When the Out-of-Pocket Maximum – Network Providers as described in Attachment C is reached, 100% of available benefits is payable for expenses for other Covered Services the Member incurs during the remainder of that Calendar Year, excluding

applicable Copayments and Penalties, and any balance of charges (the difference between Billed Charges and the Maximum Allowable Amount.)

The Out-of-Pocket Maximum – Out-of-Network Providers is unlimited. Benefits will not reach a 100% level.

39. **Payor(s)** - An insurer, health maintenance organization, no-fault liability insurer, self-insurer or other entity that provides or pays for the Member's health care benefits.
40. **Penalty/Penalties** – Additional Member Payments required as a result of failure to obtain Prior Authorization for Certain Covered Services listed in Attachment C as requiring such Prior Authorization. The Penalty will be a reduction in payment for Covered Services.
41. **Periodic Health Screening** – An assessment of patient's health status at intervals set forth in Our Medical Policy for the purpose of maintaining health and detecting disease in its early state. This assessment should include:
 - a. complete history or interval update of the patient's history and a review of systems; and
 - b. a physical examination of all major organ systems, and preventive screening tests per Our Medical Policy.
42. **Practitioner** – A person licensed by the State to provide medical services.
43. **Pre-existing Condition** – Any physical or mental condition, that was present during the 6 month period before Coverage became effective under this Plan, for which: (1) symptoms existed; (2) medical advice, diagnosis, care or treatment was recommended or received; or (3) a reasonably prudent person would have sought medical advice, diagnosis, care or treatment from a Provider of health care services.

The following will not be considered a Pre-existing Condition:

 - a. Genetic information, unless there is a diagnosis of the Condition unrelated to the genetic information.
44. **Pre-existing Condition Waiting Period** – For AccessTN, the 6-month period that begins on the date the Member's Coverage became effective, and during which benefits are reduced to 50% of the Maximum Allowable Charge for services received in connection with a Pre-existing Condition.
45. **Premium** - The total payment for Coverage under this Plan.
46. **Prior Authorization** – A review conducted by Us, prior to the delivery of certain services, to determine if such services will be considered Covered Services.
47. **Provider** – A person or entity that is engaged in the delivery of health services who or that is licensed, certified or practicing in accordance with applicable State or Federal laws.
48. **Specialty Pharmacy Products** – Injectable, infusion and select oral medications that require complex care, including special handling, patient education and continuous monitoring. Specialty Pharmacy Products are listed on the Specialty Pharmacy Products list. The list is available at www.bcbst.com or by calling the Member service number on Your membership ID card. Specialty Pharmacy Products are categorized as provider-administered or self-administered.

49. **Transplant Maximum Allowable Charge (TMAC)** - The amount that We, in Our sole discretion, have determined to be the maximum amount payable for Covered Services for Organ Transplants. Each type of Organ Transplant has a separate TMAC. That determination will be based upon Our contract with a Transplant Network Provider or the amount payable based on Our fee schedule for the Covered Services rendered by Out-of-Network Providers.
50. **Transplant Network** - A network of hospitals and facilities, each of which has agreed to perform specific organ transplants. For example, some hospitals might contract to perform heart transplants, but not liver transplants.
51. **Transplant Service** - Medically Necessary and Appropriate Services listed as Covered under the Transplant Service section in Attachment A of this Member Handbook.
52. **Urgent Care** - Medical care or treatment that, if delayed or denied, could seriously jeopardize: (1) the life or health of the claimant; or (2) the claimant's ability to regain maximum function. Urgent Care is also medical care or treatment that, if delayed or denied, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the medical care or treatment.
53. **Well Woman Exam** – A routine visit every Calendar Year to a Provider. The visit may include Medically Necessary and Medically Appropriate mammogram and cervical cancer screenings.
54. **Well Care Exam** – A routine physical examination every Calendar Year for adults. The visit may include Medically Necessary and Medically Appropriate adult immunizations and screenings.

MATERNITY AND NEWBORN COVERAGE

Your Plan provides maternity and newborn infant Coverage, subject to a 12-month waiting period. This waiting period does not apply to Members who join and who have no Pre-existing Condition Waiting Period.

Your Plan provides no separate newborn infant or dependent Coverage other than that limited coverage above available through the mother's maternity coverage. This plan provides NO newborn infant or dependent Coverage through the father's Coverage.

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., Your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce Your Out-of-Pocket costs, You may be required to obtain precertification. For information on precertification, contact Your plan administrator.

IMPORTANT NOTICE FOR MASTECTOMY PATIENTS

Patients who undergo a mastectomy, and who elect breast reconstruction in connection with the mastectomy, are entitled to Coverage in a manner determined in consultation with the attending physician and the patient for:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

The Coverage may be subject to Coinsurance and Deductibles consistent with those established for other benefits.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

LEGAL OBLIGATIONS

BlueCross BlueShield of Tennessee, Inc. is required to maintain the privacy of all medical information as required by applicable laws and regulations (hereafter referred to as our "legal obligations"); provide this notice of privacy practices to You; inform You of Our legal obligations; and advise You of additional rights concerning Your medical information. We must follow the privacy practices contained in this notice from its effective date of April 14, 2003, until this notice is changed or replaced.

We reserve the right to change privacy practices and the terms of this notice at any time, as permitted by Our legal obligations. Any changes made in these privacy practices will be effective for all medical information that is maintained including medical information created or received before the changes are made. All Subscribers will be notified of any changes by receiving a new notice of Our privacy practices.

You may request a copy of this notice of privacy practices at any time by contacting BlueCross BlueShield of Tennessee, Privacy Office, 1 Cameron Hill Circle, Chattanooga, TN 37402.

ORGANIZATIONS COVERED BY THIS NOTICE

This notice applies to the privacy practices of BlueCross BlueShield of Tennessee and its subsidiaries or affiliated covered entities. Medical information about Our Subscribers and Members may be shared with each other as needed for treatment, payment or health care operations.

USES AND DISCLOSURES OF MEDICAL INFORMATION

Your medical information may be used and disclosed for treatment, payment, and health care operations, for example:

TREATMENT: Your medical information may be disclosed to a doctor or hospital that asks for it to provide treatment to You.

PAYMENT: Your medical information may be used or disclosed to pay claims for services, which are Covered under Your health insurance plan.

HEALTH CARE OPERATIONS: Your medical information may be used and disclosed to determine premiums, conduct quality assessment and improvement activities, to engage in care coordination or case management, accreditation, conducting and arranging legal services, and for other similar administrative purposes.

AUTHORIZATIONS: You may provide written authorization to use Your medical information or to disclose it to anyone for any purpose. You may revoke Your authorization in writing at any time. That revocation will not affect any use or disclosure permitted by Your authorization while it was in effect. We cannot use or disclose Your

medical information for any reason except those described in this notice, without Your written authorization.

PERSONAL REPRESENTATIVE: Your medical information may be disclosed to a family member, friend or other person as necessary to help with Your health care or with payment for Your health care. You must agree We may do so, as described in the Individual Rights section of this notice below.

UNDERWRITING: Your medical information may be received for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a health insurance or benefits contract. If We do not issue that contract, Your medical information will not be used or further disclosed for any other purpose, except as required by law.

MARKETING: Your medical information may be used to provide information about health-related benefits, services or treatment alternatives that may be of interest to You. Your medical information may be disclosed to a business associate assisting us in providing that information to You. You may opt-out of receiving further information (see the instructions for opting out at the end of this notice), unless the information is provided to You in a newsletter or in person or concerns products or services of nominal value.

RESEARCH: Our legal obligations permit Your medical information to be used or disclosed for research purposes. If You die, Your medical information may be disclosed to a coroner, medical examiner, funeral director or organ procurement organization.

AS REQUIRED BY LAW: Your medical information may be used or disclosed as required by state or federal laws.

COURT OR ADMINISTRATIVE ORDER: Medical information may be disclosed in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances.

VICTIM OF ABUSE: If You are reasonably believed to be a victim of abuse, neglect, domestic violence or other crimes, medical information may be released to the extent necessary to avert a serious threat to Your health or safety or to the health or safety of others. Medical information may be disclosed, when necessary, to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

MILITARY AUTHORITIES: Medical information of Armed Forces personnel may be disclosed to Military authorities under certain circumstances. Medical information may be disclosed to authorized federal officials as required for lawful intelligence, counterintelligence, and other national security activities.

INDIVIDUAL RIGHTS

You have the right to look at or get copies of Your medical information, with limited exceptions. **You must make a written request, using a form available from the Privacy Office, to obtain access to Your medical information.** If You request copies of Your medical information, We will charge \$.25 per page, \$10 per hour for staff time required to copy that information, and postage if You want the copies mailed to You. If You request an alternative format, the charge will be based upon Our cost of providing Your medical information in that format. If You prefer, We will prepare a summary or explanation of Your medical information for a fee. For a more detailed explanation of the fee structure, please contact the Privacy Office. We will require advance payment before copying Your medical information.

You have the right to receive an accounting of any disclosures of Your medical information made by Us or a business associate for any reason, other than treatment, payment, health care operations purposes after April 14, 2003. This accounting will include the date the disclosure was made, the name of the person or entity the disclosure was made to, a description of the medical information disclosing the reason for the disclosure, and certain other information. If You request an accounting more than once in a 12-month period, there may be a reasonable cost-based charge for responding to those additional requests. Please contact the Privacy Office for a more detailed explanation of the fees charged for such accountings.

You have the right to request restrictions on Our use or disclosure of Your medical information We are not required to agree to such requests. **We will only restrict the use or disclosure of Your medical information as set forth in a written agreement that is signed by a representative of the Privacy Office on behalf of BlueCross BlueShield of Tennessee.**

If You reasonably believe that sending confidential medical information to You in the normal manner will endanger You, You have the right to make a written request, We communicate that information to You by a different method or to a different address. **If there is an immediate threat, You may make that request by calling a Member service representative or The Privacy Officer at 1-888-455-3824 and follow up with a written request when feasible.** We must accommodate Your request if it is reasonable, specifies how and where to communicate with You, and continues to permit us to collect premium and pay claims under Your health Plan.

You have the right to make a written request that We amend Your medical information. **Your request must explain why the information should be amended.** We may deny Your request if the medical information You seek to amend was not created by Us or for other reasons permitted by Our legal obligations. If Your request is denied, We will provide a written explanation of the denial. If You disagree, You may submit a written statement that will be included with Your medical information. If We accept Your request, We will make reasonable efforts to inform the people that You designate about that amendment and will amend any future disclosures of that information.

If you receive this notice on Our web site or by electronic mail (e-mail), You may request a written copy of this notice, by contacting the Privacy Office.

QUESTIONS AND COMPLAINTS

If You want more information concerning the companies' privacy practices or have questions or concerns, please contact the Privacy Office.

If:

- You are concerned that We have violated Your privacy rights; or
- You disagree with a decision made about access to Your medical information or in response to a request You made to amend or restrict the use or disclosure of Your medical information; or
- You wish to request We communicate with You by alternative means or at alternative locations;

please contact the Privacy Office.

You may also submit a written complaint to the U.S. Department of Health and Human Services. We will furnish the address where You can file a complaint with the U.S. Department of Health and Human Services upon request.

We support Your right to protect the privacy of Your medical information. There will be no retaliation in any way if You choose to file a complaint with Us or with the U.S. Department of Health and Human Services.

**The Privacy Office
BlueCross BlueShield of Tennessee, Inc.
1 Cameron Hill Circle
Chattanooga, TN 37402
(888) 455-3824
(423) 763-3520 FAX
Privacy_office@bcbst.com**

**ATTACHMENT A:
COVERED SERVICES AND LIMITATIONS ON COVERED SERVICES**

We pay the Maximum Allowable Charge for Medically Necessary and Appropriate services and supplies described below and provided in accordance with the reimbursement schedules set forth in Attachment C of this Member Handbook. Charges in excess of the reimbursement rates set forth in the Schedule of Benefits are not eligible for reimbursement or payment. To be eligible for reimbursement or payment, all services or supplies must be provided in accordance with Our Medical Policy and Medical Management procedures. (See the Medical Policy and Medical Management Section.)

Covered Services and Limitations set forth in this Attachment are arranged according to:

- Eligible Providers; and
- Eligible services.

An advantage of using PPO Network Providers is these Providers have agreed to accept the Maximum Allowable Charge We set for Covered Services. Network Providers have also agreed not to bill Members for amounts above these amounts.

However, Out-of-Network Providers do not have a contract with Us. This means they may be able to charge Members more than the allowable amount We set in Our contracts. With Out-of-Network Providers, Members will be responsible for any difference between what We pay and what Members are charged.

Obtaining services not listed in this Attachment or not in accordance with Our Medical Policy and Medical Management procedures may result in the denial of payment or a reduction in reimbursement for otherwise eligible Covered Services.

ELIGIBLE PROVIDERS OF SERVICE

A. Practitioners

All services must be rendered by a Practitioner type listed in Our Provider Directory of Network Providers, or as otherwise required by Tennessee law. The services provided by a Practitioner must be within his or her specialty or degree. All services must be rendered by the Practitioner or the delegate actually billing for the Practitioner, and be within the scope of his or her licensure.

B. Network Provider

A Provider who has contracted with Us to provide Covered Services.

C. Non-Contracted Provider

A provider that renders Covered Services to a Member but is in a specialty category or type with which We do not contract.

D. Out-of-Network Provider

Any Provider who is an eligible Provider type but who does not hold a contract with Us to provide Covered Services.

E. Other Providers of Service

An individual or facility, other than a Practitioner, duly licensed to provide Covered Services.

F. Continuation of Care

Benefits will be available at Out-of-Network levels for Covered Services received from a Network Provider after such Practitioner or Provider terminates its agreement with Us, or We terminate such agreement without cause.

ELIGIBLE SERVICES AND LIMITATIONS ON ELIGIBLE SERVICES

A. Practitioner Office Services

Medically Necessary and Appropriate services in a Practitioner's office.

1. Covered

- a. Well Woman Exams and other appropriate screenings and related diagnostics (See Preventive Services.)
- b. Well Care Exam every Calendar Year (See Preventive Services.)
- c. Rehabilitative therapies.
- d. Prostate screenings.
- e. Injections and medications administered in a Practitioner's office, including Specialty Pharmacy Products. (See Provider Administered Specialty Pharmacy Products section for information on Coverage).
- f. Allergy care including basic testing, evaluations, serum and injections.
- g. Casts and dressings.
- h. Nutritional guidance and education.
- i. Foot care necessary to prevent the complications of an existing disease state.
- j. Second surgical opinions, given by a Practitioner who is not in the same medical group as the Practitioner who initially recommended surgery.
- k. Services and supplies for the diagnosis and treatment of illness or injury including those relating to hearing, speech, voice or language other than for a functional nervous disorder.
- l. Pre and post-natal maternity care and delivery. There is a 12 month waiting period before maternity benefits will be provided, except for Members not subject to the Pre-existing Condition Waiting Period.
- m. Emergency conditions presented to the Practitioner's Office.

2. Exclusions

- a. Routine foot care for the treatment of flat feet, corns, bunions, calluses, toenails, fallen arches, weak feet or chronic foot strain, except as otherwise indicated under section **X. Diabetes Treatment** .
- b. Rehabilitative therapies in excess of the limitations of the Therapeutic/ Rehabilitative benefit.
- c. Office visits and physical exams for: (1) school; (2) camp; (3) employment; (4) travel; (5) insurance; (6) marriage or legal proceedings; and (7) related immunizations and tests (except immunizations for foreign travel).
- d. Foot orthotics, shoe inserts and custom made shoes, except as required by law for diabetic patients or as a part of a leg brace.

B. Preventive Services

Medically Necessary and Appropriate services for assessing physical status and detecting abnormalities. The frequency of visits and services are based on guidelines from Our Medical Policy and Medical Management procedures.

1. Covered

- a. A Well Woman Exam every Calendar Year, including any follow-up care. This visit includes cervical cancer screenings and mammogram screenings within the following guidelines:
 - (1) Once as a baseline mammogram for ages 35-39;
 - (2) Once every plan year for ages 40 and over; or
 - (3) When prescribed by a physician.
- b. A Well Care Exam for adults, every Calendar Year. This visit may include:
 - Blood pressure screening.
 - Periodic cholesterol screening.
 - Laboratory procedures to detect colon and rectal cancer.
 - Flu shot.
 - Tetanus-diphtheria (Td) booster.
 - Pneumococcal immunization.
 - Other recommended adult immunizations and immunizations not received in childhood.
 - Other prescribed x-ray and lab screenings associated with preventive care.
 - Vision and hearing screenings performed by the physician during the preventive health exam.
 - Immunizations needed for foreign travel.
 - Prostate screenings, subject to the following conditions:
 - Annually for men who have been treated for prostate cancer with radiation therapy, surgery or chemotherapy;

- Annually for men over age 45 who have enlarged prostates as determined by rectal examination; and
- Annually for men of any age with prostate nodules or other irregularity noted on rectal exam.
- Flexible sigmoidoscopy.
- Double contrast barium enema.
- Colonoscopy.

Some of these services are not needed every year, or may be appropriate only for people of particular age groups, gender, or those who meet other specific health criteria.

2. Exclusions

- a. Preventive Services not listed as Covered.
- b. Services not provided in accordance with Our Medical Policy guidelines.

C. Office Surgery

Medically Necessary and Appropriate surgeries/procedures performed in a Practitioner's office. Surgeries involve an excision or incision of the body's skin or mucosal tissues, treatment of broken or dislocated bones, and/or insertion of instruments for exploratory or diagnostic purposes into a natural body opening.

1. Covered

- a. Excisions of skin lesions (including mole removal,) and incisions.
- b. Surgical repairs, including suturing lacerations.
- c. Removal of foreign bodies from skin, eyes or orifices.
- d. Biopsies.
- e. Sigmoidoscopy, pharyngoscopy or other endoscopies.
- f. Colposcopy.
- g. Incision and drainage of abscess.
- h. Cyst aspiration.
- i. Toenail excision.
- j. Casting and splinting.
- k. Joint injection and drainage.
- l. Cryosurgery of skin lesions and cervical lesions.
- m. Vasectomy.

2. Exclusions

- a. Dental procedures, except as otherwise indicated in this Member Handbook.
- b. Procedures that require precertification (or Prior Authorization) and/or special consent, in accordance with Our Medical Policy and Medical

Management procedures for which Prior Authorization was not provided. Call Our Member service department to find out which surgeries require Prior Authorization.

D. Special Surgical Procedure – Bariatric Surgery

The plan will cover as outlined below, four surgical procedures for treatment of morbid obesity:

1. Vertical banded gastroplasty accompanied by gastric stapling.
2. Gastric segmentation along the vertical axis with a Roux-en-Y bypass with distal anastomosis placed in the jejunum.
3. Gastric banding.
4. Duodenal switch/biliopancreatic bypass: this procedure is only appropriate for persons with a BMI in excess of 60. See (5) below.

The following criteria must be met before benefits are available for the procedures listed above:

5. Presence of morbid obesity that has persisted for at least five years, defined as either:
 - a. Body mass index (BMI) exceeding 40; or
 - b. BMI greater than 35 in conjunction with the following severe co-morbidities that are likely to reduce life expectancy:
 - (1) Coronary artery disease; or
 - (2) Type 2 diabetes mellitus; or
 - (3) Obstructive sleep apnea; or
 - (4) Three or more of the following cardiac risk factors:
 - (i) Hypertension (BP>140 mmHg systolic and/or 90mmHg diastolic);
 - (ii) Low high density lipoprotein cholesterol (HDL less than 40mg/dL);
 - (iii) Elevated low-density lipoprotein cholesterol (LDL>100 mg/dL);
 - (iv) Current cigarette smoking;
 - (v) Impaired glucose tolerance (2-hour blood glucose>140 mg/dL on an oral glucose tolerance test);
 - (vi) Family history of early cardiovascular disease in first-degree relative (myocardial infarction at age under 50 in male relative or at age under 65 for female relative);
 - (vii) Age greater than 45 years in men and 55 years in women.
 - c. BMI exceeding 60 for consideration of the Duodenal Switch/Biliopancreatic Bypass procedure.
6. History of failure of medical/dietary therapies (including low calorie diet, increased physical activity, and behavioral reinforcement). This attempt at conservative management must be within two years prior to surgery, and must

be documented by an attending physician who does not perform bariatric surgery. (Failure of conservative therapy is defined as an inability to lose more than ten percent of body weight over a six-month period and maintain weight loss.)

7. There must be documentation of medical evaluation of the individual for the condition of morbid obesity and/or its co-morbidities by a physician other than the operating surgeon and his/her associates, and documentation that this evaluating physician concurs with the recommendation for bariatric surgery.

Prior Authorization is required.

E. Inpatient Hospital Services

Medically Necessary and Appropriate services and supplies in a Hospital that: (1) is a licensed Acute care institution; (2) provides inpatient services; (3) has surgical and medical facilities primarily for the diagnosis and treatment of a disease and injury; and (4) has a staff of Physicians licensed to practice medicine or provides 24 hour nursing care by graduate registered nurses. Psychiatric hospitals are not required to have a surgical facility.

Prior Authorization for Covered Services must be obtained or benefits will be reduced or denied.

1. Covered

- a. Room and board in a semi-private room (or private room if room and board charges are the same as for a semi-private room or Authorized by Us); general nursing care; medications; injections; diagnostics and special care units.
- b. Attending Practitioner's services for professional care.
- c. Observation stays.
- d. Maternity and delivery services. There is a 12 month waiting period before maternity benefits will be provided, except for Members not subject to the Pre-existing Condition Waiting Period.
- e. Blood/plasma is Covered unless free.

2. Exclusions

- a. Inpatient stays primarily for therapy (such as physical or occupational therapy.)
- b. Private duty nursing.
- c. Services that could be provided in a less intensive setting.
- d. Services that are not ordered or provided.

F. Outpatient Facility Services

Medically Necessary and Appropriate diagnostics, therapies and surgeries occurring in an outpatient facility that includes: (1) outpatient surgery centers; (2) the outpatient center of a hospital; and (3) outpatient diagnostic centers.

Prior Authorization for certain outpatient surgeries must be obtained from Us or benefits will be reduced or denied. Call Our Member service department to find out which surgeries require Prior Authorization.

1. Covered

- a. Practitioner services.
- b. Outpatient diagnostics (such as x-rays and laboratory services.)
- c. Outpatient treatments (such as medications and injections.)
- d. Outpatient surgery and supplies.
- e. Observation stays.

2. Exclusions

- a. Rehabilitative therapies are subject to the terms of the Therapeutic/ Rehabilitative benefit.
- b. Services that could be provided in a less intensive setting.

G. Hospital Emergency Care Services

Medically Necessary and Appropriate health care services and supplies furnished in a Hospital that are required to determine, evaluate and/or treat an Emergency medical condition until such condition is stabilized, as directed or ordered by the Practitioner or Hospital protocol.

Once the medical condition has stabilized, Prior Authorization must be obtained from Us for inpatient care or transfer to another facility. Benefits will be denied or reduced if Authorization is not obtained within 24 hours, or by the next working day.

1. Covered

- a. Medically Necessary and Appropriate Emergency services, supplies and medications necessary for the diagnosis and stabilization of the Member's Emergency condition.
- b. Practitioner services.

2. Exclusions

- a. Treatment of a chronic, non-Emergency condition where the symptoms have existed over a period of time, and a prudent layperson who possesses an average knowledge of health and medicine would not believe it to be an Emergency.

H. Home Health Services

Medically Necessary and Appropriate services and supplies provided in the Member's home by a Practitioner who is primarily engaged in providing home health care services. Home visits by a skilled nurse require Prior Authorization. Therapy performed in the home does not require Prior Authorization.

1. Covered

- a. Part-time, intermittent health services, supplies and medications, by or under the supervision of a registered nurse. Home health aide is also covered subject to following limitations:
 - (1) Visit shall be 4 or fewer hours;
 - (2) Service must be ordered by a physician;
 - (3) A professional nurse must conduct intermittent visits; and
 - (4) The home health aide service is in conjunction with Medically Necessary skilled care.
- b. Home Infusion Therapy.
- c. Rehabilitative therapies such as physical therapy, occupational therapy, etc. (subject to the limitations of the Therapeutic/Rehabilitative benefit.)
- d. Medical social services.
- e. Dietary guidance.
- f. Services are limited to a maximum number of visits per Calendar Year. (This limit does not apply to Home Infusion Therapy.) The maximum number of visits is shown in Attachment C.

2. Exclusions

- a. Items such as non-treatment services or: (1) routine transportation; (2) homemaker or housekeeping services; (3) behavioral counseling; (4) supportive environmental equipment; (5) maintenance or Custodial Care; (6) social casework; (7) meal delivery; (8) personal hygiene; and (9) convenience items.
- b. Our Medical Policy and Medical Management procedures may limit the number of visits per hour per day.

I. Therapeutic/Rehabilitative Services

Medically Necessary and Appropriate therapeutic and rehabilitative services intended to restore or improve bodily function lost as the result of illness or injury, or cleft palate.

1. Covered

- a. Outpatient, home health or office therapeutic and rehabilitative services that are expected to result in significant and measurable improvement in the Member's condition resulting from an Acute disease or injury. The services must be performed by, or under the direct supervision of a licensed therapist, upon written authorization of the treating Practitioner.
- b. Therapeutic/rehabilitative services include: (1) physical therapy; (2) speech therapy for restoration of speech; (3) occupational therapy; (4) manipulative therapy; and (5) cardiac and pulmonary rehabilitative services.

Speech therapy is only Covered for disorders of articulation and swallowing, resulting from Acute illness, injury, stroke, or cleft palate.

- c. Coverage is limited to a maximum number of treatment visits per therapy per Calendar Year for the following therapies: (1) physical therapy; (2) speech therapy; (3) occupational therapy; and (4) manipulative therapy. (See Attachment C.)
- d. Coverage for pulmonary and Phase II cardiac rehabilitative services is limited to a maximum number of visits per Calendar Year. (See Attachment C.)
- e. The services must be performed in a doctor's office, outpatient facility or Home Health setting. The limit on the number of visits for therapy applies to all visits for that therapy, regardless of the place of service.
- f. Services received during an inpatient hospital, skilled nursing or rehabilitative facility stay (including Phase I cardiac rehabilitative services) are Covered as shown in the inpatient hospital, skilled nursing or rehabilitative facility section, and are not subject to the therapy visit limits.
- g. Biofeedback therapy determined to be medically necessary with a maximum benefit of five sessions per plan year for each of the following conditions:
 - (1) Chronic pain;
 - (2) Incontinence;
 - (3) Migraine headaches; and
 - (4) Incapacitating stress.

2. Exclusions

- a. Treatment beyond what can reasonably be expected to significantly improve health, including therapeutic treatments for ongoing maintenance or palliative care.
- b. Enhancement therapy that is designed to improve physical status beyond the pre-injury or pre-illness state.
- c. Complementary and alternative therapeutic services, which We have determined to be not Medically Necessary. These include, but are not limited to: (1) massage therapy; (2) acupuncture; (3) craniosacral therapy; (4) neuromuscular reeducation; (5) vision exercise therapy; and (6) cognitive rehabilitation.
- d. Modalities that do not require the attendance or supervision of a licensed therapist. These include, but are not limited to: (1) activities that are primarily social or recreational in nature; (2) simple exercise programs; (3) hot and cold packs applied in the absence of associated therapy modalities; (4) repetitive exercises or tasks that can be performed by the Member without a therapist, in a home setting; (5) routine dressing changes; and (6) custodial services that can ordinarily be taught to a caregiver or the Member.
- e. Behavioral therapy, play therapy, communication therapy, and therapy for self correcting language dysfunctions as part of speech therapy, physical therapy or occupational therapy programs. Behavioral therapy and play therapy for behavioral health diagnoses may be Covered.

- f. Duplicate therapy. For example, when the Member receives both occupational and speech therapy, the therapies should provide different treatments and not duplicate the same treatment.

J. Hospice

Medically Necessary and Appropriate services and supplies for supportive care where the patient's life expectancy is 6 months or less.

1. Covered

- a. Benefits will be provided for: (1) part-time intermittent nursing care; (2) medical social services; (3) bereavement counseling; (4) medications for the control or palliation of the illness; (5) home health aide services; and (6) physical or respiratory therapy for symptom control.

2. Exclusions

- a. Services such as: (1) homemaker or housekeeping services; (2) meals; (3) convenience or comfort items not related to the illness; (4) supportive environmental equipment; (5) private duty nursing; (6) routine transportation; and (7) funeral or financial counseling.

K. Skilled Nursing/Rehabilitative Facility Services

Medically Necessary and Appropriate inpatient care provided to patients requiring medical, rehabilitative or nursing care in a restorative setting. Services are considered separate and distinct from the levels of Acute care rendered in a hospital setting, or custodial or functional care rendered in a nursing home.

Prior Authorization for Covered Services must be obtained from Us or benefits will be reduced or denied.

1. Covered

- a. Room and board in a semi-private room; general nursing care; medications; diagnostics and special care units.
- b. The attending Practitioner's services for professional care.
- c. Coverage is limited to the maximum number of days per Calendar Year shown in Attachment C.

2. Exclusions

- a. Custodial, domiciliary or private duty nursing services.
- b. Skilled Nursing services not received in a Medicare certified skilled nursing facility.
- c. Services for cognitive rehabilitation.

L. Ambulance Services

Medically Necessary and Appropriate land or air transportation, services, supplies and medications by a licensed ambulance service when time or technical expertise of the transportation is essential to reduce the probability of harm to the patient.

1. Covered
 - a. Medically Necessary and Appropriate land or air transportation from the scene of an accident or Emergency to the nearest appropriate facility.
2. Exclusions
 - a. Transportation for the sole convenience of the patient.
 - b. Transportation that is not essential to reduce the probability of harm to the patient.
 - c. Services when the patient is not transported to a facility.

M. Family Planning and Reproductive Services

Medically Necessary and Appropriate family planning services and those services to diagnose and treat diseases that may adversely affect fertility.

1. Covered
 - a. Benefits for family planning, history, physical examination, diagnostic testing and genetic testing.
 - b. Sterilization procedures.
 - c. Medically Necessary and Appropriate termination of a pregnancy.
 - d. Injectable and implantable hormonal contraceptives and vaginal barrier methods including initial fitting and insertion.
 - e. Prescription contraceptive drugs and/or devices.
2. Exclusions
 - a. Services or supplies that are designed to create a pregnancy, or medically enhance the Member's level of fertility in the absence of a disease state.
 - b. Artificial insemination.
 - c. In vitro fertilization.
 - d. Fallopian tube reconstruction.
 - e. Uterine reconstruction.
 - f. Assisted Reproductive Technology (ART,) such as GIFT, ZIFT.
 - g. Fertility injections.
 - h. Fertility drugs.
 - i. Services for follow up care related to infertility treatments.
 - j. Services or supplies for the reversals of sterilizations.
 - k. Elective abortions. Elective abortions do not include those performed when: (1) the life of the mother is in danger; (2) the pregnancy is the result of rape or incest; (3) the fetus is not viable; or (4) the fetus has been diagnosed with a lethal or otherwise significant abnormality.

N. Reconstructive Surgery

Medically Necessary and Appropriate surgical procedures intended to restore normal form or function.

1. Covered

- a. Surgery to correct significant defects from congenital causes, accidents or disfigurement resulting from a disease.
- b. Reconstructive breast surgery as a result of a mastectomy (other than lumpectomy.) Surgery on the non-diseased breast needed to establish symmetry between the two breasts.

2. Exclusions

- a. Services, supplies or prosthetics primarily to improve appearance.
- b. Surgeries to correct or repair the results of a prior surgical procedure, the primary purpose of which was to improve appearance.
- c. Surgeries and related services to change gender.

O. Durable Medical Equipment

Medically Necessary and Appropriate medical equipment or items that, in the absence of illness or injury, are of no medical or other value to the Member. Items that can withstand repeated use in an ambulatory or home setting. Items that: (1) require the Prescription of a Practitioner for purchase; (2) are approved by the FDA for the illness or injury for which it is prescribed; and (3) are not for the Member's convenience. Amounts above \$500 require Prior Authorization.

1. Covered

- a. Rental of Durable Medical Equipment- Maximum Allowable rental charge, not to exceed the total Maximum Allowable Charge for purchase. If the same type of equipment is obtained from multiple DME Providers and the total rental charges from the multiple Providers exceed the purchase price of a single piece of equipment, the Member will be responsible for amounts in excess of the Maximum Allowable Charge for purchase.
- b. The repair, adjustment or replacement of components and accessories necessary for the effective functioning of Covered Durable Medical equipment.
- c. Supplies and accessories necessary for the effective functioning of Covered Durable Medical Equipment.
- d. The replacement of items needed as the result of normal wear and tear, defects, or beyond repair.
- e. Continuous passive motion machine (CPMM) is Covered subject to the following:
 - (1) For knee replacement surgery or anterior cruciate ligament repair.
 - (2) Up to 28 days of post operative care. Further use shall be dictated by Medical Necessity.

Other uses of the CPMM shall be considered experimental or Investigational.

2. Exclusions

- a. Charges exceeding the total cost of the Maximum Allowable Charge to purchase the Durable Medical Equipment.
- b. Unnecessary repair, adjustment or replacement or duplicates of any such Durable Medical Equipment.
- c. Supplies and accessories that are not necessary for the effective functioning of the Covered Durable Medical Equipment.
- d. Items to replace those that were lost, damaged, stolen or prescribed as a result of new technology.
- e. Items that require or are dependent on alteration of home, workplace or transportation vehicle.
- f. Motorized scooters, exercise equipment, hot tubs, pools, saunas, “deluxe” or “enhanced” equipment. In all instances, the most basic equipment needed to provide the medical care will determine the benefit.

P. Prosthetics/Orthotics

Medically Necessary and Appropriate devices used to correct or replace all or part of a body organ or limb, which may be malfunctioning or missing due to: (1) birth defect; (2) accident; (3) illness; or (4) surgery.

1. Covered

- a. The initial purchase of surgically implanted prosthetic or orthotic devices.
- b. The repair, adjustment or replacement of components and accessories necessary for the effective functioning of Covered equipment.
- c. Splints and braces that are custom made or molded and are incident to a Practitioner’s services or on a Practitioner’s order.
- d. The replacement of Covered items that need replacement due to normal wear and tear, defects or beyond repair.
- e. The initial purchase of artificial limbs, eyes, or the first pair of eyeglasses or contact lenses prescribed as a result of a cataract operation. Replacement of the original limb prosthesis if a severe medical condition to the stump could result from improper fitting of the initial prostheses as determined by a physician. Replacement must be within 12 months of the initial purchase of the limb prostheses and proof of medical severity must be furnished. Prior Authorization must be obtained for the initial purchase or replacement of an artificial limb.
- f. Cochlear Implantation – using FDA approved implants and provided all the following criteria are met:

For adults (age 19 and over)

- (1) Diagnosis of post-lingual profound deafness;
- (2) Patient has achieved little or no benefit from a hearing aid;

- (3) Patient is free from middle ear infection, has an accessible cochlear lumen that is structurally suited to implantation and is free from lesions in the auditory nerve and acoustic areas of the central nervous system;
- (4) Patient has cognitive ability to use auditory clues and is psychologically and motivationally suitable to undergo an extended program of rehabilitation; and
- (5) Patient has no contraindications to surgery.

g. Foot orthotics are a covered expense for the following:

- (1) Therapeutic shoes if they are an integral part of a leg brace and are medically necessary, as determined by the claims administrator, for the proper functioning of the brace.,
- (2) Therapeutic shoes, limited to one pair per plan year (depth or custom - molded) including inserts and medically necessary modifications for plan members with diabetes mellitus and with any of the following complications:
 - (a) peripheral neuropathy with evidence of callus formation; or
 - (b) History of pre-ulceratic calluses; or
 - (c) History of previous ulceration, or
 - (d) Foot deformity, or
 - (e) Previous amputation of the foot or part of the foot; or
 - (f) Poor circulation.
- h. Rehabilitative foot orthotics that are prescribed as part of post-surgical or post-traumatic casting care
- i. Prosthetic shoes, limited to one per lifetime, that are an integral part of prosthesis and medically necessary, as determined by the claims administrator, for members with a partial foot
- j. Ankle orthotics, ankle-foot orthoses, and knee-ankle-foot orthoses when medically necessary, as determined by the claims administrator.

2. Exclusions

- a. Hearing aids.
- b. Prosthetics primarily for cosmetic purposes, including but not limited to wigs, or other hair prosthesis or transplants.
- c. Items to replace those that were lost, damaged, stolen or prescribed as a result of new technology.
- d. The replacement of eyeglasses or contacts after the initial pair has been provided following cataract surgery.

- e. Foot orthotics, shoe inserts and custom made shoes except as required by law for diabetic patients or as a part of a leg brace.
- f. Penile prosthesis due to psychogenic impotence.

Q. Supplies

Medically Necessary and Appropriate expendable and disposable supplies for the treatment of disease or injury.

1. Covered

- a. Supplies for the treatment of disease or injury used in a Practitioners office, outpatient facility or inpatient facility.
- b. Supplies for treatment of disease or injury that cannot be obtained without a Practitioner's Prescription.

2. Exclusions

- a. Supplies that can be obtained without a Prescription. (Except for diabetic supplies.) Examples include but are not limited to: (1) Band-Aids; (2) dressing material for home use; (3) antiseptics, (4) medicated creams and ointments; (5) Q-tips; and (6) eyewash.
- b. Supplies used in the home setting or otherwise for self-use, unless prescribed by a Practitioner and are both Medically Necessary and Appropriate.

R. Organ Transplants

Medically Necessary and Appropriate services and supplies provided to You, when You are the recipient of the following organ transplant procedures: (1) heart; (2) heart/lung; (3) bone marrow; (4) lung; (5) liver; (6) pancreas; (7) pancreas/kidney; (8) kidney; (9) small bowel; and (10) small bowel/liver transplants.

Transplant services or supplies that have not received Prior Authorization will not be Covered. "Prior Authorization" is the pre-treatment authorization which must be obtained from Us before any pre-transplant evaluation or any Covered Procedure is performed. (See Prior Authorization Procedures below.)

1. Prior Authorization Procedures

To obtain Prior Authorization, the patient or Practitioner must contact the Plan's Transplant Case Management department before pre-transplant evaluation or transplant services are received. Authorization should be obtained as soon as possible after the patient has been identified as a possible candidate for transplant services.

Transplant Case Management is a mandatory program for those Members seeking Transplant Services. Call the toll-free number on the front of the membership ID card for customer service and Transplant Case Management. We must be notified of the need for a transplant in order for it to be a Covered Service.

2. Covered Services

The following Medically Necessary and Appropriate transplant services and supplies which have received Prior Authorization and are provided in connection with a Covered Procedure:

- a. Medically Necessary and Appropriate services and supplies, otherwise Covered under this program;
- b. Medically Necessary and Appropriate services and supplies for each listed organ transplant are Covered only when Transplant Case Management approves a transplant
- c. Travel expenses for Your evaluation prior to a Covered Procedure, and to and from the site of a Covered Procedure by: (1) private car; (2) ground or air ambulance; or (3) public transportation. This includes Your travel expenses and an approved companion. Travel benefits are available from the initial evaluation to one year after the transplant for Medically Necessary visits.
 - i. Travel by private car is limited to reimbursement at the State of Tennessee mileage rate in effect at the time of travel from Your home to and from a facility in the Network.
 - ii. Meals and lodging expenses are Covered and are limited to \$150 daily.
 - iii. The aggregate limit for travel and lodging expenses is \$15,000 per Covered Procedure. This limit for travel and lodging is not included in the Calendar Year Organ Transplant Services supplemental benefit.
- d. Donor Organ Procurement. If the donor is not a Member, Covered Services for the donor are limited to those services and supplies directly related to the transplant service itself: (1) testing for the donor's compatibility; (2) removal of the organ from donor's body; (3) preservation of the organ; and (4) transportation of the organ to the site of transplant. Services are Covered only to the extent not covered by other health coverage. The search process and securing the organ are also Covered under this benefit. Complications of donor organ procurement are not Covered. The cost of Donor Organ Procurement is included in the total cost of Your Organ Transplant.

3. Conditions/Limitations

The following limitations and/or conditions apply to services, supplies or Charges:

- a. You or Your Practitioner must notify Transplant Case Management prior to Your receiving any transplant service, including pre-transplant evaluation, and obtain Prior Authorization. If Transplant Case Management is not notified, the transplant and related procedures will not be Covered at all;
- b. Transplant Case Management will coordinate all transplant services, including pre-transplant evaluation. You must cooperate with Us in coordination of these services;
- c. Failure to notify Us of proposed transplant services, or to coordinate all transplant related services with Us, will result in the reduction or exclusion of payment for those services;
- d. You must go through Transplant Case Management and receive Prior Authorization for Your transplant to be Covered;
- e. Bone marrow transplantation will fall into one of three categories: syngeneic, allogeneic or autologous. Expenses eligible for coverage include the charge to harvest bone marrow for covered persons diagnosed with any covered malignant condition or any conditions approved for coverage by the claims administrator. Coverage for harvesting, procurement, and storage of stem

cells, whether obtained from peripheral blood, cord blood, or bone marrow will be covered when re-infusion is scheduled within three months or less. Autologous bone marrow transplantation is considered investigational in the treatment of other malignancies, including primary intrinsic tumors of the brain.

4. Exclusions

The following services, supplies and Charges are not Covered under this section:

- a. **If You do not receive Prior Authorization, the transplant and related services will not be Covered;**
- b. Any service specifically excluded under Attachment B, Exclusions from Coverage, except as otherwise provided in this section;
- c. Services or supplies not specified as Covered Services under this section;
- d. Any attempted Covered Procedure that was not performed, except where such failure is beyond Your control;
- e. Non-Covered Services;
- f. Services which would be covered by any private or public research fund, regardless of whether You applied for or received amounts from such fund;
- g. Any non-human, artificial or mechanical organ;
- h. Payment to an organ donor or the donor's family as compensation for an organ, or payment required to obtain written consent to donate an organ;
- i. Donor services including screening and assessment procedures which have not received Prior Authorization from Us;
- j. Removal of an organ from a Member for purposes of transplantation into another person, except as Covered by the Donor Organ Procurement provision as described above;
- k. Harvest, procurement, and storage of stem cells, whether obtained from peripheral blood, cord blood, or bone marrow when reinfusion is not scheduled within three (3) months of harvest;
- l. Other non-organ transplants (e.g., cornea) are not Covered under this Section, but may be Covered as an Inpatient Hospital Service or Outpatient Facility Service, if Medically Necessary.

S. Dental Services

Medically Necessary and Appropriate services performed by a doctor of dental surgery (DDS,) a doctor of medical dentistry (DMD) or any Practitioner licensed to perform dental related oral surgery except as indicated below.

1. Covered

- a. Dental services and oral surgical care resulting from an injury to the jaw, sound natural teeth, mouth, or face, due to external trauma.
- b. Orthodontic treatment for the correction of facial hemiatrophy or congenital birth defect which impairs a bodily function.
- c. Inpatient or outpatient expenses, including anesthesia, for which Prior Authorization has been obtained, in connection with a dental procedure that includes:

- (1) Complex oral surgical procedures that have a high probability of complications due to the nature of the surgery;
 - (2) Concomitant systemic disease for which the patient is under current medical management and that significantly increases the probability of complications;
 - (3) Mental illness or behavioral condition that precludes dental surgery in the office; or
 - (4) Use of general anesthesia and the Member's medical condition requires that such procedure be performed in a Hospital.
- d. Removal of impacted teeth, including wisdom teeth.
 - e. Excision of solid based oral tumors.

2. Exclusions

- a. The facility charges for surgery will be Covered under the conditions of the inpatient or outpatient facility benefit.
- b. Treatment for routine dental care and related services including, but not limited to: (1) crowns; (2) caps; (3) plates; (4) bridges; (5) dental x-rays; (6) fillings; (7) periodontal surgery; (8) prophylactic removal of non-impacted wisdom teeth; (9) root canals; (10) preventive care (cleanings, x-rays); (11) replacement of teeth (including implants, false teeth, bridges); (12) bone grafts (alveolar surgery); (13) treatment of injuries caused by biting and chewing; (14) treatment of teeth roots; and (15) treatment of gums surrounding the teeth.
- c. Treatment for correction of underbite, overbite, and misalignment of the teeth including, but not limited to orthognathic surgery, occlusal splints and braces for dental indications.
- d. Professional Charges except as indicated above.

T. Temporomandibular Joint Dysfunction (TMJ)

Medically Necessary and Appropriate services to diagnose and treat temporomandibular joint syndrome or dysfunction (TMJ or TMD).

1. Covered

- a. Diagnosis and management of TMJ or TMD. Non-surgical treatment of TMJ or TMD is limited as indicated in Attachment C.
- b. Surgical treatment of TMJ or TMD, if performed by a qualified oral surgeon or maxillofacial surgeon.
- c. Non-surgical TMJ includes: (1) history exam; (2) office visit; (3) x-rays; (4) diagnostic study casts; (5) medications; and (6) appliances to stabilize jaw joint, not to alter teeth.

2. Exclusions

- a. Treatment for correction of underbite, overbite, and misalignment of the teeth including but not limited to, orthognathic surgery, occlusal splints and braces for dental indications.
- b. Prosthodontic treatment (dentures, bridges).
- c. Restorative treatment (fillings, crowns).
- d. Full mouth rehabilitation (restorations, extractions).
- e. Equilibrations (shaving, shaping, reshaping teeth).

U. Diagnostic Services

Medically Necessary and Appropriate diagnostic radiology services and laboratory tests.

- 1. Covered
 - a. Non-Routine Diagnostic Services.
 - b. All other Diagnostic Services.
- 2. Exclusions
 - a. Diagnostic services that are not Medically Necessary and Appropriate.
 - b. Diagnostic Services not ordered by a Practitioner.

V. Behavioral Health Services

Medically Necessary and Appropriate care and treatment of behavioral health disorders. All inpatient levels of care, which include Acute care, residential care, partial hospital care, electro-convulsive therapy (ECT) and intensive outpatient programs must receive Prior Authorization.

Benefits are available for Medically Necessary and Appropriate treatment of mental health and substance abuse disorders (behavioral health conditions) characterized by abnormal functioning of the mind or emotions and in which psychological, emotional or behavioral disturbances are the dominant features.

Benefits for Outpatient Substance Abuse treatment are combined with Mental Health visits to determine yearly visit limits and lifetime maximums.

Coinurance amounts for Behavioral Health Services do not apply to the Out-of-Pocket Maximums.

Outpatient Behavioral Health Services are not subject to any Pre-existing Condition Waiting Period.

Call the toll-free number indicated on the back of Your membership ID card if You have questions about Your Behavioral Health Services benefit.

- 1. Covered
 - a. Inpatient and outpatient services for care and treatment of mental health disorders and substance abuse disorders.
 - b. We may substitute other levels of care for inpatient days as follows:

- (1) One and one-half residential treatment days for 1 inpatient day.
- (2) Two partial hospital days for 1 inpatient day.
- (3) Five intensive outpatient program days for 1 inpatient day.

2. Exclusions

- a. Non-emergency behavioral health acute care, residential care, partial hospitalization, intensive outpatient programs stays or treatment in halfway houses or group homes and electroconvulsive treatments that are not Prior Authorized during the Member's treatment in a facility or program, whether the facility or program is an in-network Provider or an Out-of-Network Provider. Emergency Care Services require a notification within 24 hours to receive Authorization.
- b. Pastoral counseling.
- c. Marriage and family counseling without a behavioral health diagnosis.
- d. Vocational and educational training and/or services.
- e. Custodial or domiciliary care.
- f. Services related to Mental Retardation, Learning Disorders or Developmental Disabilities, Disorders or Delays as described in the International Classification of Disease Manual (ICD)
- g. Habilitative as opposed to rehabilitative services, i.e., services to achieve a level of functioning the individual has never attained.
- h. Any care in lieu of legal involvement or incarceration.
- i. Hypnosis or regressive hypnotic techniques.
- j. Charges for telephone consultations, missed appointments, completion of forms, or other administrative services.
- k. Methadone maintenance therapy.
- l. Buprenorphine maintenance therapy.
- m. Any International Classification of Disease (ICD) codes that are not included in the code range from 290 to, and including, 314.9.

W. Vision

Medically Necessary and Appropriate diagnosis and treatment of diseases and injuries that impair vision.

1. Covered

- a. Services and supplies for the diagnosis and treatment of diseases and injuries to the eye.
- b. First set of eyeglasses or contact lenses required to adjust for vision changes due to cataract surgery and obtained within 6 months following the surgery.

2. Exclusions

- a. Services, surgeries and supplies to detect or correct refractive errors of the eyes.
- b. Eyeglasses, contact lenses and examinations for the fitting of eyeglasses and contact lenses.
- c. Any expenses for tinting, glare and scratch-resistant coating for Covered lenses.
- d. Expenses for progressive lenses.
- e. Eye exercises and/or therapy.
- f. Visual training.

X. Diabetes Treatment

Medically Necessary and Appropriate diagnosis and treatment of diabetes. In order to be Covered, such services must be prescribed and certified by a Practitioner as Medically Necessary. The treatment of diabetes consists of medical equipment, supplies, and outpatient self-management training and education, including nutritional counseling.

1. Covered

- a. Blood glucose monitors, including monitors designed for the legally blind;
- b. Test strips for blood glucose monitors;
- c. Visual reading and urine test strips;
- d. Insulin;
- e. Injection aids;
- f. Syringes;
- g. Lancets;
- h. Insulin pumps, infusion devices, and appurtenances;
- i. Oral hypoglycemic agents;
- j. Podiatric appliances for prevention of complications associated with diabetes;
- k. Glucagon emergency kits;
- l. Medically Necessary routine foot care for individuals with a diagnosis of diabetes to include: diabetic shoes and inserts, nail clipping, and treatment for corns and calluses.
- m. Outpatient self-management training and education, including medical nutrition counseling, limited to \$500 per plan year. Available initially and when condition changes.

2. Exclusions

- a. Treatments or supplies that are not prescribed and certified by a Practitioner as being Medically Necessary.

- b. Supplies not required by state statute.

Y. PHARMACY PRESCRIPTION DRUG PROGRAM

BENEFITS FOR PRESCRIPTION DRUGS

At the Network Pharmacy, the Member will pay the lesser of the Copayment or the Pharmacy's charge.

Copayments vary based on the days supply dispensed.

Some products may be subject to additional Quantity Limitations as adopted by Us.

No Drug Copayment amounts apply to satisfying any Deductible or Out-of-Pocket Maximums in the Plan.

If the Member or the prescribing physician chooses a Brand Name Drug when a Generic Drug equivalent is available, the Member will be financially responsible for the amount by which the cost of the Brand Name Drug exceeds the Generic Drug cost plus the required Generic Drug copayment.

If the Member has a Prescription filled at an Out-of-Network Pharmacy, he or she must pay all expenses and file a claim for reimbursement with Us.

Reimbursement is based on the Maximum Allowable Charge, less any applicable Brand Name Drug Deductible, Coinsurance, and/or Drug Copayment amount.

BENEFITS FOR SELF-ADMINISTERED SPECIALTY PHARMACY PRODUCTS

There is a distinct network for Specialty Pharmacy Products: the specialty pharmacy network. The Member receives the highest level of benefits when a specialty pharmacy network provider is used for self-administered Specialty Pharmacy Products. The Member may use a Network or Out-of-Network Pharmacy for a self administered Specialty Pharmacy Product for **the first month only**. Thereafter, benefits are **only** available at a Specialty Pharmacy Network Provider. (Please refer to the section on Provider Administered Specialty Pharmacy Products for Specialty Pharmacy products administered by a Provider.)

When purchasing self-administered Specialty Pharmacy Products from an Out-of-Network Pharmacy, the Member must pay all expenses and file a claim for reimbursement with Us. Reimbursement is based on the Maximum Allowable Charge, less any applicable Deductible, Coinsurance, and/or Drug Copayment amount.

Specialty Pharmacy Products are limited to a one month supply per Prescription.

1. Covered

- a. Prescription Drugs prescribed when the Member is not confined in a hospital or other facility. Prescription Drugs must be:
 - (1) prescribed on or after the Member's Coverage begins;
 - (2) approved for use by the Food and Drug Administration (FDA);
 - (3) dispensed by a licensed pharmacist;

- (4) listed on the Drug Formulary; and
- (5) not available for purchase without a Prescription.
- b. Treatment of phenylketonuria (PKU), including special dietary formulas while under the supervision of a Practitioner.
- c. Injectable insulin, and insulin needles/syringes, lancets, alcohol swabs and test strips for glucose monitoring upon Prescription.

2. Limitations

- a. Refills must be dispensed pursuant to a Prescription. If the number of refills is not specified in the Prescription, benefits for refills will not be provided beyond one year from the date of the original Prescription.
- b. There are time limits on how soon a Prescription can be refilled. If a Member requests a refill too soon, the Network Pharmacy will advise when the Prescription benefit will Cover the refill.
- c. Drugs for the treatment of onychomycosis (e.g., nail fungus) are not Covered, except for: 1) diabetics; or 2) immuno-compromised patients.
- d. Growth hormones are not Covered, except for: 1) patients with "Turner" syndrome; and 2) patients with Prader-Willi syndrome confirmed by appropriate genetic testing;
- e. Prescription and non-Prescription medical supplies, devices and appliances are not Covered, except for syringes used in conjunction with injectable medications or other supplies used in the treatment of diabetes and/or asthma;
- f. Immunizations or immunological agents, including but not limited to: 1) biological sera, 2) blood, 3) blood plasma; or 4) other blood products are not Covered, except for blood products required by hemophiliacs.
- g. Injectable drugs, are Covered only when intended for self-administration.
- h. Compound Drugs are only Covered when filled at a Network Pharmacy. The Network Pharmacy must submit the claim through the pharmacy benefit manager. The claim must contain a valid national drug code (NDC) number for at least one ingredient in the Compound Drug.
- i. Prescription Drugs that are commercially packaged or commonly dispensed in quantities less than a 30-calendar day supply (e.g. prescription items that are dispensed based on a certain quantity for a therapeutic regimen) will be subject to one Drug Copayment, provided the quantity does not exceed the FDA approved dosage for four calendar weeks.
- j. This Plan does not Cover Prescription Drugs prescribed for purposes other than for:
 - indications approved by the FDA; or
 - off-label indications recognized through published peer-reviewed medical literature or from at least one of the nationally recognized compendia (AHFS, DrugDex, or USP-DI).

- k. If the Member abuses or over uses pharmacy services outside of Our administrative procedures, We may restrict the Member's Pharmacy access. We will work with the Member to select a Network Pharmacy, and he or she can request a change in his or her Network Pharmacy.
- l. Smoking deterrents, such as patches, provided for assistance in smoking cessation. The following limitations apply to this benefit:
 - (a) Prescription must be written by a licensed physician;
 - (b) Prescriptions are for a 90-day period only; and
 - (c) Benefit is allowable once per plan year, with a maximum lifetime benefit of two 90-day periods.

3. Exclusions

In addition to the limitations and exclusions specified in Attachment B, benefits are not available for the following:

- a. drugs that are prescribed, dispensed or intended for use while the Member is confined in a hospital, skilled nursing facility or similar facility, except as otherwise Covered in the Member Handbook;
- b. any drugs, medications, Prescription devices or vitamins, available over-the-counter that do not require a Prescription by Federal or State law; and/or Prescription Drugs dispensed in a doctor's office are excluded except as otherwise Covered in the Plan;
- c. any quantity of Prescription Drugs that exceed that specified by the P & T Committee;
- d. any Prescription Drug purchased outside the United States, except those authorized by Us;
- e. any Prescription dispensed by or through a non-retail internet Pharmacy;
- f. medications intended to terminate a pregnancy (e.g., RU-486);
- g. non-medical supplies or substances, including support garments, regardless of their intended use;
- h. artificial appliances;
- i. allergen extracts;
- j. any drugs or medicines dispensed more than one year following the date of the Prescription;
- k. Prescription Drugs the Member is entitled to receive without charge in accordance with any worker's compensation laws or any municipal, state, or federal program;
- l. replacement Prescriptions resulting from lost, spilled, stolen, or misplaced medications (except as required by applicable law);
- m. drugs dispensed by a Provider other than a Pharmacy;
- n. administration or injection of any drugs;
- o. Prescription Drugs used for the treatment of infertility;

- p. Prescription Drugs not on the Drug Formulary;
- q. anorectics (any drug or medicine for the purpose of weight loss and appetite suppression);
- r. DESI (Drug Efficiency Safety Implementation) and LTE (Less Than Effective) Drugs;
- s. all newly FDA approved drugs prior to review by the P & T Committee;
- t. Prescription Drugs used for cosmetic purposes including, but not limited to: 1) drugs used to reduce wrinkles (e.g. Renova); 2) drugs to promote hair-growth; 3) drugs used to control perspiration; 4) drugs to remove hair (e.g. Vaniqa); and 5) fade cream products;
- u. FDA approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia;
- v. Compound drugs filled or refilled at an Out-of-Network Pharmacy;
- w. drugs used to enhance athletic performance;
- x. Experimental and/or Investigational Drugs; and
- y. Prescription Drugs or refills dispensed:
 - (1) in quantities in excess of amounts specified in Attachment C;
 - (2) without Our Prior Authorization when Prior Authorization is required; or
 - (3) that exceed any applicable Annual Maximum Benefit, or any other maximum benefit amounts stated in this Member Handbook.

These exclusions only apply to this Prescription Drug Program. Items that are excluded under this Program may be Covered as medical supplies elsewhere under the Plan. Please review the Member Handbook carefully.

4. Definitions

- a. **Average Wholesale Price** – A published suggested wholesale price of the drug by the manufacturer.
- b. **Brand Name Drug** - a Prescription Drug identified by its registered trademark or product name given by its manufacturer, labeler or distributor.
- c. **Compound Drug** - An outpatient Prescription Drug, which is not commercially prepared by a licensed pharmaceutical manufacturer in a dosage form approved by the Food and Drug Administration (FDA) and that contains at least one ingredient classified as a Legend Prescription Drug.
- d. **Drug Copayment/Copay/Coinsurance** - the dollar amount (Copayment/Copay) or percentage (Coinsurance) specified in Attachment C that the Member must pay directly to the Network Pharmacy at the time the covered Prescription Drug is dispensed. The Drug Copayment or Coinsurance is determined by the type of drug purchased, and must be paid for each Prescription Drug.

- e. **Brand Name Drug Deductible** - the amount that must be paid by the Member before benefits are provided for Brand Name Prescription Drugs under this Plan. The Brand Name Drug Deductible will not apply toward satisfying any other Deductible or Out-Of-Pocket Maximum.
- f. **Drug Formulary** - a list designating that Prescription Drugs and drug products are approved for reimbursement under this Plan. This list is subject to periodic review and modification by Us.
- g. **Experimental and/or Investigational Drugs** – Drugs or medicines that are labeled: “Caution – limited by federal law to Investigational use.”
- h. **Generic Drug** - A Prescription Drug that has the same active ingredients, strength or concentration, dosage form and route of administration as a Brand Name Drug. The FDA approves each Generic Drug as safe and effective as a specific Brand Name Drug.
- i. **Legend Drugs** – A drug that, by law, can be obtained only by Prescription and bears the label, “Caution: Federal law prohibits dispensing without a Prescription.”
- j. **Maximum Allowable Charge** – the amount that We have determined to be the maximum amount payable for a Covered Service. That determination will be based upon Our contract with a Network Provider or the amount payable based on Our fee schedule for the Covered Service.
- k. **Network Pharmacy** - a Pharmacy that has entered into a Network Pharmacy Agreement with Us or Our agent to legally dispense Prescription Drugs to the Member, either in person or through home delivery.
- l. **Non Preferred Brand Drug or Elective Drug** - a Brand Name Drug that is not considered a Preferred Drug by Us. Usually there are lower cost alternatives to some Brand Name Drugs.
- m. **Out-of-Network Pharmacy** - a Pharmacy that has not entered into a service agreement with BCBST or its agent to provide benefits under this Plan at specified rates to the Member.
- n. **Pharmacy** - a state or federally licensed establishment that is physically separate and apart from the office of a physician or authorized Practitioner, and where Legend Drugs are dispensed by Prescription by a pharmacist licensed to dispense such drugs and products under the laws of the state in which he or she practices.
- o. **Pharmacy and Therapeutics Committee or P&T Committee** - A panel of Our participating pharmacists, Network Providers, medical directors and pharmacy directors that reviews medications for safety, efficacy and cost effectiveness. The P&T Committee evaluates medications for addition and deletion from the: 1) Drug Formulary; 2) Preferred Brand Drug list; 3) Maintenance Drug list; 4) Prior Authorization Drug list; and 5) Quantity Limitation list. The P&T Committee may also set dispensing limits on medications.
- p. **Preferred Brand Drug** - Brand Name Drugs that We have reviewed for clinical appropriateness, safety, therapeutic efficacy, and cost effectiveness.

The Preferred Brand Drug list is reviewed at least annually by the P&T Committee.

- q. **Prescription Drug** - a medication containing at least one Legend Drug that may not be dispensed under applicable state or federal law without a Prescription, and/or insulin.
- r. **Prescription** - a written or verbal order issued by a physician or duly licensed Practitioner practicing within the scope of his or her licensure to a pharmacist for a drug, or drug product to be dispensed.
- s. **Prior Authorization Drugs**- Prescription Drugs that are only eligible for reimbursement after prior authorization from Us as determined by the P&T Committee.
- t. **Quantity Limitation** – Quantity limitations applied to certain Prescription Drug products as determined by the Pharmacy and Therapeutics Committee.
- u. **Specialty Pharmacy Products** – Injectable, infusion and select oral medications that require complex care, including special handling, patient education and continuous monitoring. Specialty Pharmacy Products are listed on the Specialty Pharmacy Products list. The list is available at www.bcbst.com or by calling the Member service number on Your membership ID card. Specialty Pharmacy Products are categorized as provider-administered or self-administered.

We will retain any refunds, rebates, reimbursements or other payments representing a return of monies paid for Covered Services under this Plan.

GENERIC DRUGS

Prescription drugs are classified as brand or generic. A given drug can change from brand to generic or from generic to brand. Sometimes a given drug is no longer available as a Generic Drug. These changes can occur without notice. If You have any questions, please contact Our Member service representatives.

Z. Provider Administered Specialty Pharmacy Products

Medically Necessary and Appropriate specialty pharmaceuticals for the treatment of disease, administered by a Practitioner or home health care agency. Certain Specialty Pharmacy Products require Prior Authorization or benefits will be reduced or denied. Call Member service at the number listed on the membership ID card or check Our web site (www.bcbst.com) to find out which Specialty Pharmacy Products require Prior Authorization.

1. Covered

- a. Provider administered Specialty Pharmacy Products as identified on the Specialty Pharmacy Products list (includes administration by a qualified provider).

2. Exclusions

- a. See Prescription Drug Program section for coverage of Self-administered Specialty Pharmacy Products.

ATTACHMENT B: LIMITATIONS AND EXCLUSIONS

LIMITATIONS

Benefits for services and supplies (except Outpatient Behavioral Health Services, outpatient chemotherapy and radiation therapy drugs used for the treatment of cancer, and Prescription medications) for a Pre-existing Condition during the Pre-existing Condition Waiting Period will be reduced to 50% of the Maximum Allowable Charge. Coinsurance for a Pre-existing Condition will not apply to the Out-of-Pocket Maximum.

This Limitation does not apply to Members who became Covered under AccessTN Portability Coverage immediately after eighteen (18) months prior creditable coverage without a significant break in coverage and who were:

- a. losing TennCaresm coverage; or
- b. exhausting any continuation coverage; or
- c. losing group coverage without a continuation option; or
- d. aging out of CoverKids by exceeding the maximum age for coverage under that program.

EXCLUSIONS FROM COVERAGE

When a service or supply is excluded, all related expenses, services and supplies will also be excluded.

This Plan does not provide benefits for the following services, supplies or charges:

1. Services or Supplies not listed as Covered Services under Attachment A: Covered Services.
2. Services or supplies that are determined to be not Medically Necessary and Appropriate or have not been authorized by Us.
3. Services or supplies that are Investigational in nature including, but not limited to: (1) drugs, (2) biologicals; (3) medications; (4) devices; and (5) treatments.
4. When more than one treatment alternative exists, each is Medically Appropriate and Medically Necessary, and each would meet the Member's needs, We reserve the right to provide payment for the least expensive Covered Service alternative.
5. Illness or injury resulting from war and covered by: (1) veteran's benefit; or (2) other coverage for which the Member is legally entitled and that occurred before the Member's Coverage began under this Plan.
6. Self-treatment or training.
7. Staff consultations required by hospital or other facility rules.
8. Services that are free.
9. Services required because of illness or injury related to the Member's participation in a felony, attempted felony, riot or insurrection.

10. Services or supplies for the treatment of work related illness or injury, regardless of the presence or absence of workers' compensation coverage. This exclusion does not apply to injuries or illnesses resulting from self-employment.
11. Personal, physical fitness, recreational or convenience items and services such as: (1) barber and beauty services; (2) television; (3) air conditioners; (4) humidifiers; (5) air filters; (6) heaters; (7) physical fitness equipment; (8) saunas; (9) whirlpools; (10) water purifiers; (11) swimming pools; and (12) tanning beds. Other recreational services or equipment including: (1) weight loss programs; (2) physical fitness programs; or (3) self-help devices that are not primarily medical in nature, even if ordered by a Practitioner.
12. Services or supplies received before the Member's effective date for Coverage under this Plan.
13. Services or supplies related to a Hospital Confinement, received before the Member's effective date for Coverage under this Plan.
14. Services or supplies received after Coverage under this Plan ceases for any reason. This is true even though the expenses relate to a condition that began while the Member was Covered.
15. Telephone or email consultations, or charges for failure to keep a scheduled appointment or charges to complete a claim form or to provide medical records.
16. Services for providing requested medical information or completing forms. We will not charge the Member for statutorily authorized copying charges.
17. Court ordered examinations and treatment, unless Medically Necessary.
18. Room, board and general nursing care rendered on the date of discharge, unless admission and discharge occur on the same day.
19. Charges in excess of the Maximum Allowable Charge for Covered Services or any charges that exceed the Lifetime Maximum.
20. Any service stated in Attachment A as a non-Covered Service or limitation.
21. Charges for Services performed by You or Your spouse, or Your or Your spouse's parent, sister, brother or child.
22. Services for which the Member is not legally obligated to pay or for which no charge would be made if the Member had no health Coverage.
23. Any charges for handling fees.
24. Safety items, or items to affect performance primarily in sports-related activities.
25. Services or supplies related to cosmetic services, including surgical or other services, drugs or devices. Cosmetic services include, but are not limited to: (1) removal of tattoos; (2) facelifts; (3) keloid removal; (4) dermabrasion; (5) chemical peels; (6) rhinoplasty; (7) breast augmentation; and (8) breast reduction.
26. Services or supplies related to treatment of complications (except Complications of Pregnancy) that are a direct or closely related result of a Member's refusal to accept treatment, medicines, or a course of treatment that a Provider has recommended or that has been determined to be Medically Necessary. This includes leaving an inpatient medical facility against the advice of the treating physician.

27. Blepharoplasty and browplasty, except for: (1) correction of injury to the orbital area resulting from physical trauma or non-cosmetic surgical procedures (e.g., removal of malignancies); (2) treatment of edema and irritation resulting from Grave's disease; or (3) correction of trichiasis, ectropion, or entropion of the eyelids.
28. Sperm preservation.
29. Services and supplies for orthognathic surgery.
30. Services and supplies for Maintenance Care.
31. Private duty nursing.
32. Pharmacogenetic testing.
33. Services or supplies for methadone maintenance therapy and buprenorphine maintenance therapy.
34. Cranial orthosis, including helmet or headband, for the treatment of plagiocephaly.

**ATTACHMENT C:
SCHEDULE OF BENEFITS**



BlueCross BlueShield of Tennessee
1 Cameron Hill Circle | Chattanooga, TN 37402
bcbsst.com

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association.
Habla español or another language? For more information about alternative formats and interpreter services, call 1-866-636-0080.

TDD/TTY users should call 1-866-591-2908. These services are free to enrollees.

No one is discriminated against because of race, sex, religion, color, national or ethnic group, age, disability, or military services.
You may file written complaints about discrimination by writing to Cover Tennessee, Benefits Division, 26th Floor WRS Tennessee
Tower, 312 Rosa L. Parks Ave., Nashville, TN 37243.

This document has been classified as public information