

Attachment C - Schedule of Benefits

AccessTN Plan Three

Benefit percentages apply to the BCBST Maximum Allowable Charge (MAC). Network level applies to services received from Network Providers and Non-Contracted Providers.

Out-of-Network benefit percentages apply to BCBST Maximum Allowable Charge. **Member is responsible for any amount exceeding the Maximum Allowable Charge for services received from Out-of-Network Providers and Non-Contracted Providers.**

To receive the maximum benefit from this Coverage, make sure the Provider is a member of the Provider Network shown on the membership ID card.

Plan Year is Calendar Year, January 1 through December 31.

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Service Received at the Practitioner's office		
Office Services for Preventive Care		
Benefits for Specified Preventive Care Services are available once per Calendar Year, not subject to Deductible, as listed below. For details on the current list of Covered Preventive Care services, please see Your Member Handbook or call Member Services at 1-866-636-0080.		
Well Woman Exam, including Preventive Mammogram and Cervical Cancer screening	100%	60% of MAC after Deductible
Annual health assessment, including Prostate Cancer screening and specified other screenings Specified preventive non-invasive colorectal screening (does not include flexible sigmoidoscopy or colonoscopy) Specified immunizations	100%	60% of MAC after Deductible
Preventive Care Services other than those specified above by the Plan as payable at 100%	80% after Deductible	60% of MAC after Deductible
Screening flexible sigmoidoscopy and screening colonoscopy	80% after Deductible	60% of MAC after Deductible

Office Services for Diagnosis and Treatment of Illness or Injury

Some procedures require Prior Authorization. Call Member Services to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, benefits will be reduced to 50% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for penalty when Tennessee Network Providers do not obtain Prior Authorization.

Office visits for diagnosis and treatment of Illness or Injury.		
Primary Care Practitioner types (Family Practice, Internal Medicine, Pediatrics, Obstetrics & Gynecology, Physician Assistants, Nurse Practitioners)	80% after Deductible	60% of MAC after Deductible
All other Practitioners	80% after Deductible	60% of MAC after Deductible
Office Surgery, including anesthesia		
Primary Care Practitioner types (Family Practice, Internal Medicine, Pediatrics, Obstetrics & Gynecology, Physician Assistants, Nurse Practitioners)	80% after Deductible	60% of MAC after Deductible
All other Practitioners	80% after Deductible	60% of MAC after Deductible
Maternity care (subject to 12-month waiting period)	80% after Deductible	60% of MAC after Deductible
Allergy Testing	80% after Deductible	60% of MAC after Deductible
Allergy injections and allergy serum	80% after Deductible	60% of MAC after Deductible
All other injections	80% after Deductible	60% of MAC after Deductible
Non-Routine Diagnostic Services: CAT scans, MRI's, PET scans, nuclear medicine and other similar technologies.	80% after Deductible	60% of MAC after Deductible
All Other Diagnostic Services for illness or injury	80% after Deductible	60% of MAC after Deductible
Therapy Services: Physical, speech, occupational, and manipulative limited to 45 visits per therapy type per Calendar Year. Cardiac rehabilitative therapy is limited to 3 times per week for 12 weeks. Pulmonary rehabilitative therapy limited to certain conditions.	80% after Deductible	60% of MAC after Deductible
Durable Medical Equipment (DME), Limited to \$3,000 per Calendar Year	80% after Deductible	60% of MAC after Deductible
Orthotics and Prosthetics	80% after Deductible	60% of MAC after Deductible
Supplies	80% after Deductible	60% of MAC after Deductible
Behavioral Health Services Limited to 45 visits per Calendar Year	80% not subject to Deductible	60% of MAC not subject to Deductible
Provider Administered Specialty Pharmacy Products Some Specialty medications require Prior Authorization. Call Member Services to determine if Prior Authorization is required.	80% after Deductible	60% of MAC after Deductible

Services Received at a Facility		
Inpatient Hospital Stays		
Prior Authorization required. Benefits will be reduced to 50% for Out-of-Network Providers when Prior Authorization is not obtained. Benefits will be reduced to 50% for Network Providers outside Tennessee (BlueCard PPO Providers) when Prior Authorization is not obtained. Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for penalty when Tennessee Network Providers do not obtain Prior Authorization.		
Facility Charges	80% after Deductible	60% of MAC after Deductible
Practitioner Charges	80% after Deductible	60% of MAC after Deductible
Facility Charges related to Maternity (subject to 12-month waiting period)	80% after Deductible	60% of MAC after Deductible
Practitioner Charges related to Maternity (subject to 2-month waiting period)	80% after Deductible	60% of MAC after Deductible
Behavioral Health Services Limited to 30 days per calendar year	80% after Deductible	60% of MAC after Deductible
Substance Abuse Treatment Limited to 2 Inpatient stays per lifetime, maximum of 28 days per stay. Detoxification limited to 2 Inpatient stays per lifetime, maximum of 5 days per stay.	80% after Deductible	60% of MAC after Deductible
Skilled Nursing or Rehabilitative Facility stays:		
Limited to 45 days per Calendar Year for Skilled Nursing Facility		
Prior Authorization required. Benefits will be reduced to 50% for Out-of-Network Providers when Prior Authorization is not obtained. Benefits will be reduced to 50% for Network Providers outside Tennessee (BlueCard PPO Providers) when Prior Authorization is not obtained. Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for penalty when Tennessee Network Providers do not obtain Prior Authorization.		
Facility Charges	80% after Deductible	60% of MAC after Deductible
Practitioner charges	80% after Deductible	60% of MAC after Deductible
Hospital Emergency Care services		
In the event of a true medical Emergency, Covered Services received at a hospital emergency department from an Out-of-Network Provider will be paid at the Network Provider benefit level (80%), including the Network Deductible. If Covered Services received at a hospital emergency department from an Out-of-Network Provider are determined NOT to be a true medical Emergency, then the Out-of-Network Deductible and Benefit level (60%) will apply, in addition to the Copayment.		
Facility Charges Copayment is waived if admitted.	\$75 Copayment, then 80% after Deductible	\$75 Copayment, then 80% of MAC after Deductible
Practitioner charges	80% after Deductible	80% of MAC after Deductible
Outpatient Facility Services		
Outpatient Surgery		
Some procedures require Prior Authorization. Call Member Services to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, benefits will be reduced to 50% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for penalty when Tennessee Network Providers do not obtain Prior Authorization.		
Surgeries include invasive diagnostic services (e.g. colonoscopy, sigmoidoscopy)		
Facility Charges	80% after Deductible	60% of MAC after Deductible
Practitioner charges	80% after Deductible	60% of MAC after Deductible

Outpatient Diagnostic Services		
Some procedures require Prior Authorization. Call Member Services to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, benefits will be reduced to 50% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for penalty when Tennessee Network Providers do not obtain Prior Authorization.		
Non-Routine Diagnostic Services for illness or injury: CAT scans, MRI's, PET scans, nuclear medicine and other similar technologies.	80% after Deductible	60% of MAC after Deductible
All other diagnostic services for illness or injury	80% after Deductible	60% of MAC after Deductible
Diagnostic services for maternity care Subject to 12-month waiting period	80% after Deductible	60% of MAC after Deductible
Diagnostic Services for Behavioral Health Services	80% after Deductible	60% of MAC after Deductible
Outpatient Services for Preventive Care		
Benefits for Specified Preventive Care Services are available once per Calendar Year, not subject to Deductible, as listed below. For details on the current list of Covered Preventive Care services, please see www.bcbst.com .		
Preventive Mammogram, Cervical Cancer screening, Prostate Cancer screening and other specified screenings	100%	60% of MAC after Deductible
Preventive non-invasive colorectal screening (does not include flexible sigmoidoscopy or colonoscopy)	100%	60% of MAC after Deductible
Specified Immunizations	100%	60% of MAC after Deductible
Other Preventive Care Screenings	80% after Deductible	60% of MAC after Deductible
Screening colonoscopy or screening flexible sigmoidoscopy	80% after Deductible	60% of MAC after Deductible
Other Outpatient procedures, services, or supplies		
Therapy Services: Physical, speech, occupational, and manipulative limited to 45 visits per therapy type per Calendar Year. Cardiac rehabilitative therapy is limited to 3 times per week for 12 weeks. Pulmonary rehabilitative therapy limited to certain conditions.	80% after Deductible	60% of MAC after Deductible
Durable Medical Equipment (DME) Limited to \$3,000 per Calendar Year	80% after Deductible	60% of MAC after Deductible
Orthotics and Prosthetics	80% after Deductible	60% of MAC after Deductible
Supplies	80% after Deductible	60% of MAC after Deductible
Provider Administered Specialty Pharmacy Products Some Specialty medications require Prior Authorization. Call Member Services to determine if Prior Authorization is required.	80% after Deductible	60% of MAC after Deductible
All Other services received at an outpatient facility, including chemotherapy, radiation therapy, injections, infusions, and renal dialysis	80% after Deductible	60% of MAC after Deductible

Prescription Drugs			
<p>Limited to \$100,000 per Calendar year (there may be additional limits for specific drugs). Supplemental outpatient pharmacy coverage for anti-hemophilic factor which extends the max to \$150,000 is provided. Benefits are available for a 34 day supply at retail and up to a 102 day supply through home delivery or home delivery at retail.</p>			
<p>If Generic is available and You or Your physician elect a Brand or Preferred Brand, You will be required to pay the difference between the Brand or Preferred Brand and Generic</p>	<p>\$15 Copayment for Generic Drugs</p>		<p>You pay all costs, then file for reimbursement. You will be reimbursed based on the Maximum Allowable Charge less any Copayment or Deductible amounts.</p>
	<p>30% Copayment (Maximum of \$75) for Preferred Brand Name Drugs</p>		
	<p>60% Copayment (Maximum of \$150) for Brand Name Drugs</p>		
<p>Self Administered Specialty Pharmacy products, as indicated on Our Specialty Pharmacy Products list Benefits are limited to 1 month supply Some Specialty medications require Prior Authorization. Call Member Services to determine if Prior Authorization is required.</p>			
Specialty Pharmacy Products	Benefits for Covered Services received from Specialty Pharmacy Network Providers	Benefits for Covered Services received from Network Pharmacies	Benefits for Covered Services received from Out-of-Network Pharmacies
	60% Copayment (Maximum of \$150)	60% Copayment (Maximum of \$300)	You pay all costs, then file for reimbursement. You will be reimbursed based on the Maximum Allowable Charge less any Copayment or Deductible amount
<p>If a drug that is on Our Specialty Pharmacy Products list is also a Generic Drug or a Preferred Brand Drug, then Your Copayment will be:</p>			
A Generic Drug that is also a Self Administered Specialty Pharmacy product, as indicated on Our Specialty Pharmacy Products list	\$15 Copayment	\$30 Copayment	<p>You pay all costs, then file for reimbursement. You will be reimbursed based on the Maximum Allowable Charge less any Copayment or Deductible amount</p>
A Preferred Brand Drug that is also a Self Administered Specialty Pharmacy product, as indicated on Our Specialty Pharmacy Products list	30% Copayment (Maximum of \$75)	30% Copayment (Maximum of \$150)	

Other Services			
Ambulance		80% after Deductible	80% of MAC after Deductible
Home Health Care Services, including home infusion therapy Prior Authorization is required. Limited to 30 visits per Calendar Year		80% after Deductible	60% of MAC after Deductible
Hospice Care		100%	60% of MAC after Deductible
Durable Medical Equipment (DME), Limited to \$3,000 per Calendar Year		80% after Deductible	60% of MAC after Deductible
Orthotics and Prosthetics		80% after Deductible	60% of MAC after Deductible
Supplies		80% after Deductible	60% of MAC after Deductible
Organ Transplant Services Supplemental Benefit of \$100,000 per Calendar Year			
Organ Transplant Services, all transplants except kidney All Organ Transplants require Prior Authorization. Benefits will be denied without Prior Authorization. Transplant Network Providers are different from Network Providers for other services. Call Member Services before any pre-transplant evaluation or other transplant service is performed to request Authorization, and to obtain information about Transplant Network Providers. Network Providers that are not in the Transplant Network may balance bill the Member for amounts over TMAC not Covered by the Plan.	Transplant Network 80% after Network Deductible; Network Out -of-Pocket Maximum applies	Network Providers not in Our Transplant Network (Network Providers not in our Transplant Network include Network Providers in Tennessee and BlueCard PPO Providers outside Tennessee) 80% of Transplant Maximum Allowable Charge (TMAC) after Network Deductible, Network Out-of-Pocket Maximum applies. Amounts over TMAC do not apply to the Out-of-Pocket Maximum and are not Covered.	Out-of-Network Providers 60% of Transplant Maximum Allowable Charge (TMAC), after Out-of-Network Deductible, Out-of-Network Out-of-Pocket Maximum applies. Amounts over TMAC do not apply to the Out-of-Pocket Maximum and are not Covered.
Organ Transplant Services, kidney transplants All Organ Transplants require Prior Authorization. Benefits will be denied without Prior Authorization. Transplant Network Providers are different from Network Providers for other services. Call Member Services before any pre-transplant evaluation or other transplant service is performed to request Authorization, and to obtain information about Transplant Network Providers. Network Providers that are not in the Transplant Network may balance bill the Member for amounts over TMAC not Covered by the Plan.	Network Providers: 80% after Network Deductible; Network Out-of-Pocket Maximum applies	Out-of-Network Providers: 60% of Maximum Allowable Charge (MAC), after Out-of-Network Deductible, Out-of-Network Out-of- Pocket Maximum applies. Amounts over MAC do not apply to the Out-of- Pocket and are not Covered.	

Miscellaneous Benefit Limits: (Per Calendar Year, except as noted)		
Lifetime Maximum	\$1 million	
Maximum Calendar Year Benefit (includes medical and pharmacy)	\$200,000	
Maximum Calendar Year Supplemental Transplant Benefit	\$100,000	
Temporomandibular Joint (TMJ) - non-surgical treatment	\$1,500 per Calendar Year	
Outpatient Behavioral Health Services (not subject to Deductible, or Pre-existing Condition Waiting Period)	45 sessions	
Inpatient Behavioral Health Services	30 days per year	
Pre-Existing Condition Waiting Period NOTE: Benefits for Pre-existing Conditions will be reduced to 50% of the MAC, after Deductible, for the first 6 months of Coverage. Coinsurance for a Pre-existing Condition will not apply to the Out-of-Pocket Maximum.	6 Months	
Maternity Waiting Period	12 months	
4 th Quarter Deductible Carryover	None	
Deductible and Out-of-Pocket	Services received from Network Providers	Services received from Out-of-Network Providers
Deductible		
Individual	\$5,000	\$10,000
Out-of-Pocket Maximum (includes Deductible, but does not include any Copayments for medical services, Coinsurance for Behavioral Health Services, Copayments or Coinsurance for outpatient Prescription Drugs or any balance of charges.)		
Individual	\$10,000	Unlimited