

**Attachment C - Schedule of Benefits
HealthyTNBabies
Group II**

To receive benefits from this Plan, make sure the Provider is a member of the Provider Network shown on the membership ID card. If You receive services from an Out-of-Network Provider, You will be responsible for the full payment of the Out-of-Network Provider's charge. **No Benefits are payable for services received from Out-of-Network Providers.**

Covered Services	Copayment required for Covered Services received from Network Providers
Services Received at the Practitioner's office	
Office Services for Pre and Post-natal care (including complications) The Copayment applies only to the initial visit for the Physician managing the pregnancy and delivery. The Copayment will apply to all other non-routine maternity related visits.	
Office Visits by a Primary Care Physician	\$5 Copayment
Office Visits by a Specialist	\$5 Copayment
Routine Diagnostic Services.	No Copayment
Services Received at a Facility	
Inpatient Hospital Stays	
Prior Authorization is required for non-delivery admissions. Benefits will be denied 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 Copayment waived if readmitted within 48 hours of initial visit for same episode.	\$5 Copayment per admission
Practitioner Charges (including Midwives)	No Copayment
Hospital Emergency Care services	
In the event of a true Emergency, benefits are available from Network and Out-of-Network Providers.	
Facility Charges (Copayment waived if admitted.):	
Emergency Condition	\$5 Copayment per visit
Non-emergency Condition	\$10 Copayment per visit
Practitioner charges	No Copayment
Urgent Care services	
Facility Charges: Emergency Room	\$10 Copayment per visit
Walk-in Clinic	\$5 Copayment per visit
Practitioner charges	No Copayment

Covered Services	Copayment required for Covered Services received from Network Providers
Outpatient Facility Services and Outpatient Surgery	
Facility Charges	\$5 Copayment
Practitioner charges	No Copayment
Outpatient Diagnostic Services	
Routine and Non-Routine Diagnostic Services	No Copayment
Other Services	
Ambulance	No Copayment
Services Received at the Pharmacy	
Prescription Drugs Retail up to 30 day supply. Up to 90 day supply for one copayment through home delivery and certain retail pharmacies. If You choose a Brand Name Drug (Preferred or Non-preferred) when a Generic Drug equivalent is available, You 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. Some Specialty Pharmacy Products require Prior Authorization. Please refer to the Specialty Pharmacy Drug Listing for a list of Specialty Pharmacy products requiring Prior Authorization.	
Generic	\$1 Copayment
Preferred Brand	\$3 Copayment
Non-Preferred Brand	\$5 Copayment
Miscellaneous Limits	
Maximum Out of Pocket for all Services	5% of Family Income