

**Attachment C - Schedule of Benefits
CoverTN Plan A**

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. The benefit percentage applies to the Maximum Allowable Charge for Network Providers and Non-Contracted Providers. You may be billed for the balance of charges from a Non-Contracted Provider. No benefits are available for services received from Out-of-Network Providers.

After You reach Your Annual Maximum, You will be liable, up to the Maximum Allowable Charge, for services received from a Network Provider.

Covered Services	Benefits for Covered Services received from Network Providers	Benefit Limits
	Percentage applies to Maximum Allowable Charge	
Services Received at the Practitioner's office		
Office Services for Preventive Care Must see a Primary Care Physician (PCP). Primary Care Physicians include Family Practice, General Practice, Internal Medicine, OB/GYN and Nurse Practitioner..		
Well Woman Exam Includes: <ul style="list-style-type: none"> • Cervical cancer screening 	100%	One Well Woman Exam per Calendar Year, subject to office visit limit of twelve (12) visits per Calendar Year for medical, surgical or preventive services performed in an office setting
Preventive mammogram	100%	Included with one well woman visit per Calendar Year Mammograms performed in an outpatient setting will be subject to the outpatient visit limit of two (2) non-surgical visits per Calendar Year
Well Care Services Includes: Annual health assessment Immunizations Preventive screenings, including non-invasive colorectal or prostate cancer (does not include flexible sigmoidoscopy or colonoscopy)	100%	One Well Care exam per Calendar Year, subject to office visit limit of twelve (12) visits per Calendar Year for medical, surgical or preventive services performed in an office setting

Office Services for Diagnosis and Treatment of Illness or Injury		
<p>Services may be performed by a Primary Care Physician (PCP) or a Specialist. Primary Care Physicians include Family Practice, General Practice, Internal Medicine OB/GYN and Nurse Practitioner. Prior Authorization required for Provider Administered Specialty Pharmacy Products used in chemotherapy. The Member is required to obtain Prior Authorization when seeing a provider outside the state of Tennessee. Providers in the Member's Network inside the state of Tennessee are responsible for obtaining Prior Authorization. The Member may not be responsible for penalty when a Provider in the Member's Network fails to obtain Prior Authorization.</p>		
Office visits for diagnosis and treatment of Illness or Injury	By PCP 100% after \$15 Copay	Subject to office visit limit of twelve (12) visits per Calendar Year for medical or surgical services performed in an office setting (including preventive care visits)
	By Specialist 100% after \$15 Copay	Subject to office visit limit of five (5) visits per Calendar Year for medical, surgical or preventive services performed in an office setting
Office Surgery, including anesthesia Colonoscopies are not covered when performed in an office setting	By PCP 100% after \$15 Copay	Subject to office visit limit of twelve (12) visits per Calendar Year for medical or surgical services performed in an office setting (including preventive care visits)
	By Specialist 100% after \$15 Copay	Subject to office visit limit of five (5) visits per Calendar Year for medical, surgical or preventive services performed in an office setting
Non-routine treatments: Includes chemotherapy and radiation therapy	100%	Subject to office visit limit of five (5) visits per Calendar Year for medical, surgical or preventive services performed in an office setting
Office services related to Behavioral Health Services	100% after \$25 Copay	Outpatient Behavioral Health Services limited to ten (10) visits per Calendar Year
Routine Diagnostic Services for illness or injury Non-Routine Diagnostic Services are not covered when performed in the office.	100%	Office visit must be covered for related lab work and x-ray to be covered Does not count toward visit limit when performed separately from an office visit Office lab and x-ray services are not covered after the office visit limit is met
DME, and Prosthetics	100%	Subject to combined annual payment limit of \$500 for DME, prosthetics and medical supplies
Supplies	100%	Subject to combined annual payment limit of \$500 for DME, prosthetics and medical supplies
Services Received at a Facility		
<p>Hospital based physicians at a Network facility may be Network or Out-of-Network Providers. If they are Out-of-Network, benefits will be provided up to the Maximum Allowable Charge (the reimbursement amount for a Network Provider). You will be responsible for the difference between the benefits provided and the provider's billed charges.</p>		
Inpatient Hospital Stays		
<p>Prior Authorization required. The Member is required to obtain Prior Authorization when seeing a provider outside the state of Tennessee (a BlueCard PPO Participating Provider). Providers in the Member's Network inside the state of Tennessee are responsible for obtaining Prior Authorization. The Member may not be responsible for the penalty when a Provider in the Member's Network fails to obtain Prior Authorization.</p>		
Facility Charges	100% after \$100 Copay per admission	Subject to \$10,000 annual payment limit for inpatient medical and behavioral health services
Practitioner Charges	100%	Inpatient stay must be covered

Facility Charges related to Behavioral Health Services	100% after \$100 Copay per admission	Subject to \$10,000 annual payment limit for inpatient medical and behavioral health services Inpatient Behavioral Health Services limited to five (5) days per Calendar Year
Practitioner Charges related to Behavioral Health Services	100%	Inpatient stay must be covered

Hospital Emergency Care services
 In the event of a true Emergency, limited benefits are also available for Out-of-Network Providers. Benefits will be provided up to the Maximum Allowable Charge (the reimbursement amount for a Network Provider). You may be responsible for the difference between the benefits provided and the facility's billed charges. No benefits are available if You use an Out-of-Network Provider for a non-emergency condition. You will be responsible for all charges.

Facility Charges:		Limited to two (2) Emergency Room visits per Calendar Year
Emergency Condition	100%	
Non-emergency Condition	100% after \$100 Copay per visit	
Practitioner charges	100% after \$25 Copay per visit for both emergency and non-emergency conditions	Limited to two (2) Emergency Room visits per Calendar Year

Urgent Care services

Facility Charges:	100% after \$25 Copay per visit	Limited to two (2) non-surgical outpatient visits and one (1) surgical outpatient visit per Calendar Year
Practitioner charges (PCP)	100% after \$15 Copay	Subject to office visit limit of twelve (12) visits per Calendar Year for medical, surgical or preventive services performed in an office setting

Outpatient Facility Services and Outpatient Surgery
 Surgeries include invasive diagnostic services (e.g. colonoscopy, sigmoidoscopy)

Facility Charges	100% after \$25 Copay per visit	Subject to outpatient visit limit of one (1) surgical visit per Calendar Year
Practitioner charges	100%	Subject to outpatient visit limit of one (1) surgical visit per Calendar Year
Preventive invasive screenings (e.g. colonoscopy, sigmoidoscopy)	100%	Subject to outpatient visit limit of one (1) surgical visit per Calendar Year

Outpatient Diagnostic Services		
Non-Routine Diagnostic Services for illness or injury: CAT scans, MRI's, PET scans, nuclear medicine and other similar technologies.	100%	Subject to outpatient visit limit of two (2) non-surgical visits per Calendar Year
All other diagnostic services for illness or injury	100%	Subject to outpatient visit limit of two (2) non-surgical visits per Calendar Year
Preventive mammogram	100%	Subject to outpatient visit limit of two (2) non-surgical visits per Calendar Year
Cervical cancer screening	100%	Subject to outpatient visit limit of two (2) non-surgical visits per Calendar Year
Preventive non-invasive colorectal screening (does not include flexible sigmoidoscopy or colonoscopy)	100%	Subject to outpatient visit limit of two (2) non-surgical visits per Calendar Year
Prostate cancer screening	100%	Subject to outpatient visit limit of two (2) non-surgical visits per Calendar Year
Other Wellcare Screenings	100%	Subject to outpatient visit limit of two (2) non-surgical visits per Calendar Year

Other Outpatient procedures, services, or supplies		
Prior Authorization required for Provider Administered Specialty Pharmacy Products used in chemotherapy. The Member is required to obtain Prior Authorization when seeing a provider outside the state of Tennessee. Providers in the Member's Network inside the state of Tennessee are responsible for obtaining Prior Authorization. The Member may not be responsible for penalty when a Provider in the Member's Network fails to obtain Prior Authorization.		
Facility Charges related to Behavioral Health Services	100% after \$25 Copay per visit	Outpatient Behavioral Health Services limited to ten (10) visits per Calendar Year
Practitioner charges related to Behavioral Health Services	100%	Outpatient Behavioral Health Services limited to ten (10) visits per Calendar Year
DME and Prosthetics	100%	Subject to outpatient visit limit of two (2) non-surgical visits per Calendar Year Subject to combined annual payment limit of \$500 for DME, prosthetics and medical supplies
Supplies	100%	Subject to outpatient visit limit of two (2) non-surgical visits per Calendar Year Subject to combined annual payment limit of \$500 for DME, prosthetics and medical supplies
All Other services received at an outpatient facility, including chemotherapy and radiation therapy	100%	Subject to outpatient visit limit of two (2) non-surgical visits per Calendar Year

Other Services		
Ground Ambulance	100%	Limited to two (2) trips per Calendar Year
Home Health Care Services, including home infusion therapy	100%	Subject to annual payment limit of \$500
Hospice Care	100%	Subject to annual payment limit of \$5,000 for inpatient and/or outpatient and/or home services
DME and Prosthetics	100%	Subject to combined annual payment limit of \$500 for DME, prosthetics and medical supplies
Supplies	100%	Subject to combined annual payment limit of \$500 for DME, prosthetics and medical supplies
Vision Supplies	100%	Limited to \$200 for the first set of eyeglasses or contact lenses with 6 months following cataract surgery
Services Received at the Pharmacy		
Prescription Drugs		
Prescription Formulary Generic Drugs Benefits for Generic Drugs are limited to the Generic Drugs listed on the CoverTN Formulary.	100% after \$10 Copay per 30 day supply	Subject to Calendar Quarterly payment limit of \$250 (includes insulin, blood glucose monitors, blood glucose test strips and generic drugs). Unused benefits do not accumulate towards the next Calendar Quarter. Generic drugs purchased from an Out-of-Network Pharmacy are not Covered.
Prescription Formulary Brand Drugs Benefits for Brand Drugs are limited to Insulin and the Diabetic Supplies listed on the CoverTN Formulary.	100% after \$10 Copay per 30 day supply	Not subject to Calendar Quarterly payment limit of \$250 (includes insulin, blood glucose monitors, blood glucose test strips and generic drugs). Brand drugs purchased from an Out-of-Network Pharmacy are not Covered.
Diabetic Supplies		
Blood Glucose Monitors	100%	Not subject to Calendar Quarterly payment limit of \$250
Blood Glucose Test Strips	100% after \$10 Copay	Not subject to Calendar Quarterly payment limit of \$250
Diabetic Supplies (needles, syringes, lancets, alcohol swabs)	100% after \$5 Copay	Not subject to Calendar Quarterly payment limit

Miscellaneous Benefit Limits:	Network Providers
Annual Plan Payment Maximum – All Covered Services	\$25,000
Pre-Existing Condition Waiting Period	12 Months