

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

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 may 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, except as indicated in this Schedule.

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

<b>Covered Services</b>	<b>Benefits for Covered Services received from Network Providers</b>	<b>Benefit Limits</b>
	<b>Percentage applies to Maximum Allowable Charge</b>	
<b>Services Received at the Practitioner's office</b>		
<b>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.</b>		
Well Woman Exam Includes: <ul style="list-style-type: none"> <li>• Cervical cancer screening</li> </ul>	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 Exam per Calendar Year  Preventive mammograms performed in an outpatient setting will not be subject to the outpatient visit limit of three (3) 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

<b>Office Services for Diagnosis and Treatment of Illness or Injury</b>		
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.		
Office visits for diagnosis and treatment of Illness or Injury	By PCP 100% after \$20 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 \$20 Copay	Subject to office visit limit of six (6) 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 \$20 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 \$20 Copay	Subject to office visit limit of six (6) 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 six (6) 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
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<b>Services Received at a Facility</b>		
Limited benefits will be provided for Out-of-Network Hospital based physicians at a Network facility.		
<b>Inpatient Hospital Stays</b>		
Prior Authorization required. 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 the penalty when a Provider in the Member's Network fails to obtain Prior Authorization.		
Facility Charges	100% after \$100 Copay per admission	Subject to \$15,000 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 \$15,000 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
<b>Hospital Emergency Care services</b>		
In the event of a true Emergency, limited benefits are also available for Out-of-Network Providers. Benefits will be provided up to the Out-of-Network Maximum Allowable Charge. 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 encounter for both emergent and non-emergent conditions	Limited to two (2) Emergency Room visits per Calendar Year

<b>Urgent Care services</b>		
Facility Charges:	100% after \$25 Copay per visit	Subject to outpatient visit limit of three (3) non-surgical outpatient visits and two (2) surgical outpatient visits per Calendar Year
Practitioner charges (PCP)	100% after \$20 Copay	Subject to office visit limit of twelve (12) visits per Calendar Year for medical, surgical or preventive services performed in an office setting
<b>Outpatient Facility Services</b>		
<b>Outpatient Surgery</b>		
Surgeries include invasive diagnostic services (e.g. colonoscopy, sigmoidoscopy)		
Facility Charges	100% after \$25 Copay per visit	Subject to outpatient visit limit of three (3) non-surgical outpatient visits and two (2) surgical outpatient visits per Calendar Year
Practitioner charges	100%	Subject to outpatient visit limit of three (3) non-surgical outpatient visits and two (2) surgical outpatient visits per Calendar Year
Preventive invasive screenings (e.g. colonoscopy, sigmoidoscopy)	100%	Subject to outpatient visit limit of two (2) surgical visits per Calendar Year

<b>Outpatient Diagnostic Services</b>		
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 three (3) non-surgical visits per Calendar Year
All other diagnostic services for illness or injury	100%	Subject to outpatient visit limit of three (3) non-surgical visits per Calendar Year
Mammogram	100%	Preventive mammograms performed in an outpatient setting will not be subject to the outpatient visit limit of three (3) non-surgical visits per Calendar Year. All other mammograms will be subject to outpatient visit limit of three (3) non-surgical visits per Calendar Year
Cervical cancer screening	100%	Subject to outpatient visit limit of three (3) 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 three (3) non-surgical visits per Calendar Year
Prostate cancer screening	100%	Subject to outpatient visit limit of three (3) non-surgical visits per Calendar Year
Other Wellcare Screenings	100%	Subject to outpatient visit limit of three (3) non-surgical visits per Calendar Year

<b>Other Outpatient procedures, services, or supplies</b>		
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
All Other services received at an outpatient facility, including chemotherapy and radiation therapy	100%	Subject to outpatient visit limit of three (3) non-surgical visits per Calendar Year

<b>Other Services</b>		
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
Vision Supplies	100%	Limited to \$200 for the first set of eyeglasses or contact lenses within 6 months following cataract surgery

<b>Services Received at the Pharmacy</b>		
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<b>Prescription Drugs</b>		
Prescription Drug Formulary Generic Drugs Benefits for Generic Drugs are limited to the Generic Drugs listed on the CoverTN Drug Formulary.	100% after \$8 Copay per 30 day supply	Subject to Calendar Quarterly payment limit of \$75. Unused benefits do not accumulate towards the next Calendar Quarter. Generic drugs purchased from an Out-of-Network Pharmacy are not Covered.
Prescription Drug Formulary Diabetic Brand Drugs (insulin and test strips)	100% after \$10 Copay per 30 day supply	Not subject to Calendar Quarterly payment limit of \$75. Brand drugs purchased from an Out-of-Network Pharmacy are not Covered.
Prescription Drug Formulary Brand Drugs Benefits for Brand Drugs are limited to certain drugs used to treat the flu as listed on the CoverTN Formulary.	100% after \$25 Copay per 30 day supply	Not subject to Calendar Quarterly payment limit of \$75. Brand drugs purchased from an Out-of-Network Pharmacy are not Covered.

<b>Diabetic Supplies</b>		
Blood Glucose Monitors	100%	Not subject to Calendar Quarterly payment limit of \$75
Diabetic Supplies (needles, syringes, lancets, alcohol swabs)	100% after \$5 copay	Not subject to Calendar Quarterly payment of \$75

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