



CoverTN is a Limited Benefit Plan and does not provide financial protection in the event of a major illness or accident.



## **COVERTN MEMBER HANDBOOK**

### **NOTICE**

**PLEASE READ THIS MEMBER HANDBOOK CAREFULLY AND KEEP IT IN A SAFE PLACE FOR FUTURE REFERENCE. IT EXPLAINS YOUR COVERAGE FROM BLUECROSS BLUESHIELD OF TENNESSEE. IF YOU HAVE ANY QUESTIONS ABOUT THIS MEMBER HANDBOOK OR ANY OTHER MATTER RELATED TO YOUR MEMBERSHIP IN THE PLAN, PLEASE WRITE OR CALL US AT:**

**COVERTN MEMBER SERVICES DEPARTMENT  
BLUECROSS BLUESHIELD OF TENNESSEE, INC.  
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**8:00 a.m. – 6:00 p.m. ET, M - F**

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## INTRODUCTION

This Member Handbook (this “MH”) describes the Coverage through the contract between BlueCross BlueShield of Tennessee, Inc. (BCBST, or the “Plan”) and the State of Tennessee (the “State”) Department of Finance and Administration (“Contract”). The State’s Coverage is called CoverTN. This MH describes the terms and conditions of Your Coverage from the Plan through the State. It includes all riders and attachments, which are incorporated herein by reference. It replaces and supersedes any Evidence of Coverage (EOC) or MH that You have previously received from the Plan.

**PLEASE READ THIS MH CAREFULLY. It describes your rights and duties as a Member. It is important to read the entire MH. Certain services are not covered by the plan. Other covered services are limited. The plan will 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-D.)**

The State has delegated discretionary authority to make any benefit or eligibility determinations to the Plan. It has also granted the authority to construe the terms of Your Coverage to the Plan. The Plan shall be deemed to have properly exercised that authority unless it abuses its discretion when making such determinations.

ANY GRIEVANCE RELATED TO YOUR COVERAGE UNDER THIS MH MUST BE RESOLVED IN ACCORDANCE WITH THE “GRIEVANCE PROCEDURE” SECTION OF THIS MH.

In order to make it easier to read and understand this MH, defined words are capitalized. Those words are defined in the “DEFINITIONS” section of this MH.

Please contact one of the Plan’s Member service representatives, at the number listed on Your membership ID card, if You have any questions when reading this MH. Our Member service representatives are also available to discuss any other matters related to Your Coverage from the Plan.

## WHAT IS A PPO PLAN?

BlueCross BlueShield of Tennessee’s Preferred Provider Organization (PPO) gives You a choice of doctors, hospitals and other health care providers. We have contracted with a network of health care institutions and professionals. These Providers, called Network Providers, agree to special pricing arrangements.

Your Plan provides benefits only when You use Network Providers. If You receive services from an Out-of-Network Provider, no benefits will be paid. After You have reached your Annual Benefit Limit, You will only be responsible for charges that do not exceed the Maximum Allowable Charge for services received from Network Providers. You are responsible for all charges from an Out-of-Network Provider. Attachment C: Schedule of Benefits, show Your benefits for services received from Network Providers. Attachment C also will show You that the same service might be paid differently depending on where You receive the service.

## YOUR MEMBERSHIP IDENTIFICATION CARD

Once Your Coverage becomes effective, You will receive a membership identification (ID) card. The membership ID card is the key to receiving the benefits of the health plan. Carry it at all times.

Please be sure to show the membership ID card each time You receive medical services, especially whenever a Provider recommends hospitalization.

Our Member service number is on Your membership ID card. This is an important phone number. Call this number if You have any questions. Also, call this number if You are receiving

hospital services from Providers outside of Tennessee to make sure all Prior Authorization procedures have been followed.

If a membership ID card is lost or stolen, call the toll-free number listed on the front page of this MH. Our Member service department will help You get a new one. You may want to record Your identification number in this book.

**Important:** membership ID cards should be presented at each visit to a physician's office, hospital, pharmacy or other health care facility.

### **Easy Guidelines for Getting the Most from Your Benefits**

1. Always carry Your membership ID card and show it before receiving care.
2. Always use Network Providers, including pharmacies, durable medical equipment suppliers, skilled nursing facilities and home infusion therapy Providers. See Attachment A for an explanation of a Network Provider. Call the Member service department to verify that a Provider is a Network Provider.
3. Be sure to ask Member service if the Provider is in the specific network shown on Your membership ID card. Since BCBST has several PPO networks, a Provider may be in one BCBST network, but not in all of Our networks. Check out Our website, [www.BCBST.com](http://www.BCBST.com), for more information on Providers in each PPO network.
4. To help You understand if BCBST considers a recommended service to be Medically Necessary, please refer to Our Medical Policy Manual at [www.BCBST.com](http://www.BCBST.com).
5. Use the BlueCard PPO network when You need Covered Services outside of Tennessee. Call the toll-free number shown on the back of Your membership ID card to find a network Provider outside of Tennessee.
6. In a true Emergency it is appropriate to go to an Emergency room (see Emergency definition in the Definitions Section of this MH.) However, most conditions are not Emergencies and are best handled with a call to Your doctor's office. You can also call Your doctor on nights and weekends where Our network physicians provide a covering health care professional to return Your call.
7. Ask that Your Provider report any Emergency admissions to BCBST within 24 hours or the next business day.
8. Your Network Provider is responsible for obtaining any required Prior Authorization.
9. Notify Our Member service department at the number listed on Your membership ID card if changes in the following occur for You or Your spouse:
  - a. Name.
  - b. Address.
  - c. Telephone number.
  - d. Employment (change companies or terminate employment).
  - e. Status of any other health insurance You might have.
  - f. Marriage.
  - g. Death.

### **Participating Employers**

Your or Your spouse's Employer may have agreed to be a part of CoverTN. If so, the Employer will have notified the State. The Employer will also send us a Participating Employer Agreement ("PEA"). If the Employer stops being a part of CoverTN, You can keep Your Coverage. This is explained later.

## RELATIONSHIP WITH NETWORK PROVIDERS

### A. Independent Contractors

Network Providers are not employees, agents or representatives of the Plan. Such Providers contract with the Plan, which has agreed to pay them for rendering Covered Services to You. Network Providers are solely responsible for making all medical treatment decisions in consultation with their Member-patients. The Plan does not make medical treatment decisions under any circumstances.

The Plan has the discretionary authority to make benefit or eligibility determinations and interpret the terms of Your Coverage to the Plan (“Coverage Decisions”). It makes those Coverage Decisions based on the terms of this MH, the CoverTN Agreement, its participation agreements with Network Providers and applicable State or Federal laws.

The Plan’s participation agreements permit Network Providers to dispute the Plan’s Coverage decisions if they disagree with those decisions. If Your Network Provider does not dispute a Coverage decision, You may request reconsideration of that decision as explained in the grievance procedure section of this MH. The participation agreement requires Network Providers to fully and fairly explain the Plan’s Coverage decisions to You, upon request, if You decide to request that the Plan reconsider a Coverage decision.

The Plan has established various incentive arrangements to encourage Network Providers to provide Covered Services to You in an appropriate and cost effective manner. You may request information about Your Provider’s payment arrangement by contacting the Plan’s Member service department.

### B. Termination of Provider’s Participation

The Plan or a Network Provider may end their 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. The Plan does not promise that any specific Network Provider will be available to render services while You are Covered.

## INDEPENDENT LICENSEE OF THE BLUECROSS BLUESHIELD ASSOCIATION

The Plan is an independent corporation operating under a license from the BlueCross BlueShield Association (the “Association”). That license permits the Plan to use the Association’s service marks within its assigned geographical location. The Plan is not a joint venturer, agent or representative of the Association nor any other independent licensee of the Association.

## **ELIGIBILITY FOR EMPLOYEES OF PARTICIPATING EMPLOYERS**

### **(Including Participating Local County Government)**

Any Employee or the spouse of an Employee, who meets the requirements of the CoverTN program, is eligible for Coverage if enrolled and the required premium is paid. If there is a question about whether a person is eligible for Coverage, the State shall make the final determination.

To be eligible for CoverTN, You or Your spouse must work for a Participating Employer. You must satisfy all eligibility requirements of CoverTN and You must:

- a. work at least 20 hours per week on average;
- b. work for an Employer in Tennessee;
- c. live in Tennessee or a bordering state;
- d. be a US citizen, or qualified alien;
- e. be 19 years old or older;
- f. agree to pay 1/3 of the premium
- g. not have health insurance; and
- h. not have had any health insurance in the last 6 months. (There are some exceptions.)

The spouse must satisfy all the eligibility requirements of CoverTN and must:

- a. live in Tennessee or a bordering state;
- b. be a US citizen, or qualified alien;
- c. be 19 years old or older;
- d. agree to pay 2/3 of the premium
- e. not have health insurance; and
- f. not have had any health insurance in the last 6 months. (There are some exceptions.)

Only Employees and/or their current spouse, as recognized by Tennessee law can apply for Coverage. No other dependents are eligible for Coverage under this Plan.

An Employee or spouse who resides permanently outside the US is not eligible for Coverage.

An Employee or spouse who resides permanently outside Tennessee or a bordering state is not eligible for Coverage.

## **ELIGIBILITY FOR SELF-EMPLOYED INDIVIDUALS**

Any Self-employed Individual or the spouse of a Self-employed Individual, who meet the requirements of the CoverTN program, are eligible for Coverage if enrolled and the required premium is paid. If there is a question about whether a person is eligible for Coverage, the State shall make the final determination.

To be eligible for CoverTN, You or Your spouse must satisfy all eligibility requirements of CoverTN and You must:

- a. not have any full time employees;
- b. work at least 20 hours per week on average;
- c. be a US citizen, or qualified alien;
- d. be 19 years old or older;
- e. live in Tennessee;

- f. earn less than \$55,000 per year;
- g. agree to pay 2/3 of the premium;
- h. not have health insurance; and
- i. not have had any health insurance in the last 6 months. (There are some exceptions.)

The spouse must satisfy all the eligibility requirements of CoverTN and must:

- a. live in Tennessee;
- b. be a US citizen, or qualified alien;
- c. be 19 years old or older;
- d. agree to pay 2/3 of the premium;
- e. not have health insurance; and
- f. not have had any health insurance in the last 6 months. (There are some exceptions.)

Only a Self-employed Individual and/or his or her current spouse, as recognized by Tennessee law can apply for Coverage. No other dependents are eligible for Coverage under this Plan.

A Self-employed Individual or his or her spouse who resides permanently outside the US is not eligible for Coverage.

A Self-employed Individual or his or her spouse who resides permanently outside Tennessee is not eligible for Coverage.

#### **ELIGIBILITY FOR EMPLOYEES OF NON-PARTICIPATING EMPLOYERS**

Any Employee or the spouse of an Employee of a Non-Participating Employer, who meets the requirements of the CoverTN program, is eligible for Coverage if enrolled and the required premium is paid. If there is a question about whether a person is eligible for Coverage, the State shall make the final determination.

To be eligible for CoverTN, You or Your spouse must satisfy all eligibility requirements of CoverTN, be approved for the program through the State of Tennessee and You must:

- a. work at least 20 hours per week on average;
- b. be a US citizen, or qualified alien;
- c. be 19 years old or older;
- d. live in Tennessee;
- e. earn less than \$55,000 per year;
- f. agree to pay 2/3 of the premium;
- g. not have health insurance;
- h. not have access to Employer sponsored health insurance; and
- i. not have had any health insurance in the last 6 months. (There are some exceptions.)

The spouse must satisfy all the eligibility requirements of CoverTN and must:

- a. live in Tennessee;
- b. be a US citizen, or qualified alien;
- c. be 19 years old or older;
- d. agree to pay 2/3 of the premium;
- e. not have health insurance; and
- f. not have had any health insurance in the last 6 months. (There are some exceptions.)

Only Employees and/or their current spouse, as recognized by Tennessee law can apply for Coverage. No other dependents are eligible for Coverage under this Plan.

An Employee or spouse who resides permanently outside the US is not eligible for Coverage.

An Employee or spouse who resides permanently outside Tennessee is not eligible for Coverage.

### **ELIGIBILITY FOR TENNESSEANS BETWEEN JOBS**

Any individual (called Employee in this Member Handbook), who meets the requirements of the CoverTN program, is eligible for Coverage if enrolled and the required premium is paid. If there is a question about whether a person is eligible for Coverage, the State shall make the final determination.

To be eligible for CoverTN, You or Your spouse must satisfy all eligibility requirements of CoverTN, be approved for the program through the State of Tennessee and You must:

- a. be currently unemployed and worked a minimum of 1 week in the last 6 months or work less than 20 hours each week;
- b. be a US citizen, or qualified alien;
- c. be 19 years old or older;
- d. live in Tennessee;
- e. earn less than \$55,000 per year;
- f. agree to pay 2/3 of the premium;
- g. not have health insurance; and
- h. not have access to Employer sponsored health insurance.

The spouse must satisfy all the eligibility requirements of CoverTN and must:

- a. live in Tennessee;
- b. be a US citizen, or qualified alien;
- c. be 19 years old or older;
- d. agree to pay 2/3 of the premium;
- e. not have health insurance; and
- f. not have had any health insurance in the last 6 months. (There are some exceptions.)

Only individuals and/or their current spouse, as recognized by Tennessee law can apply for Coverage. No other dependents are eligible for Coverage under this Plan.

An individual or spouse who resides permanently outside the US is not eligible for Coverage.

An individual or spouse who resides permanently outside Tennessee is not eligible for Coverage.

## **ENROLLMENT**

Eligible Employees may enroll for Coverage for themselves and their spouse as set forth in this section. No person is eligible to re-enroll, if the Plan previously terminated his or her Coverage for cause.

### **A. Initial Enrollment Period**

Eligible Employees may enroll for Coverage for themselves and their spouse within the first ninety (90) days after the State's notification:

1. that the Employer is approved as a Participating Employer under the CoverTN program;  
or
2. that the Eligible Employee and spouse is approved .

The Employee must: (1) include all requested information; (2) sign; and (3) submit a CoverTN Enrollment Form to the Plan during that initial enrollment period.

### **B. Open Enrollment Period**

Eligible Employees may enroll for Coverage for themselves and their spouse during the CoverTN Open Enrollment Period annually each October. The Employee must: (1) include all requested information; 2) sign; and (3) submit an Enrollment Form to the Plan during that Open Enrollment Period. Employees who become eligible for Coverage other than during an Open Enrollment Period may apply for Coverage for themselves and their spouse within thirty (30) days of becoming eligible for Coverage, or during a subsequent Open Enrollment Period.

### **C. Adding a Spouse**

After the Employee is Covered, he or she may apply to add a spouse, who became eligible after the Covered Employee enrolled, as follows:

1. A spouse may be added if the Covered Employee completes and submits a signed Enrollment Form to the Plan within 30 days of the date of marriage.

### **D. Late Enrollment**

Employees or their spouses who do not enroll when becoming eligible for Coverage under (A), (B) or (C), above, may be enrolled:

1. During a subsequent Open Enrollment Period; or
2. Within thirty (30) days of the Employee's marriage.

## **EFFECTIVE DATE OF COVERAGE**

If You are eligible, have enrolled and have paid or had the Premium for Coverage paid on Your behalf, Coverage under this MH shall become effective on the earliest of the following dates.

**A. Effective Date of Participating Employer Agreement (for Employees of Participating Employers)**

Initial Coverage through the Plan shall be effective on the effective date of the PEA, if all eligibility requirements are met as of that date.

**B. Enrollment During an Open Enrollment Period**

Coverage shall be effective on January 1<sup>st</sup> of the following year.

**C. Enrollment During an Initial Enrollment Period**

If the Plan processes the Enrollment Form during the 1<sup>st</sup> through the 15<sup>th</sup> of the month, Coverage shall be effective on the first day of the month following the Plan's processing of the eligible Employee's Enrollment Form. If the Plan processes the Enrollment Form from the 16<sup>th</sup> through the end of the month, Coverage shall be effective on the first day of the second month after the Enrollment Form was processed.

**D. Newly Eligible Employees**

If the Plan processes the Enrollment Form during the 1<sup>st</sup> through the 15<sup>th</sup> of the month, Coverage shall be effective on the first day of the month following the Plan's processing of the eligible Employee's Enrollment Form. If the Plan processes the Enrollment Form from the 16<sup>th</sup> through the end of the month, Coverage shall be effective on the first day of the second month after the Enrollment Form was processed.

**E. Newly Eligible Spouse**

Coverage will be effective for a Covered Employee's spouse on the day of the marriage unless otherwise agreed to by the State and the Plan.

For Coverage to be effective, the Covered Employee's spouse must be enrolled, and the Plan must receive any required Premium for the Coverage, as set out in the "Enrollment" section.

**F. Premium Payment**

CoverTN is part of the Cover Tennessee program. If the Employer is a Participating Employer in the program:

1. The State pays 1/3 of the premium
2. The Employer pays 1/3 of the premium.
3. The Covered Employee pays 1/3 of the premium.

If You are the Spouse, the Employer may not pay a portion of the premium.

If the Employer is a Participating Employer and You live in one of the bordering states:

1. The State pays no premium.
2. Either the Employer or the Member pays the State portion in addition to their 1/3 of the Premium.

If the Employee who is a Tennessee resident leaves the Employer, but keeps the CoverTN Coverage:

1. The State pays 1/3 of the premium.
2. You pay 2/3 of the Premium.

If You are a Tennessee resident and the Employer stops being part of the CoverTN program, and You keep Your CoverTN Coverage:

1. The State pays 1/3 of the premium.
2. You pay 2/3 of the premium.

If You are an Employee of a Participating Local County Government:

1. The County pays 2/3 of the premium.
2. You pay 1/3 of the premium.

If the Employer is a Non-Participating Employer:

1. The State pays 1/3 of the premium.
2. You pay 2/3 of the premium.

If You are a Self-employed Individual:

1. The State pays 1/3 of the premium.
2. You pay 2/3 of the premium.

If You are a Tennessean Between Jobs:

1. The State pays 1/3 of the premium.
2. You pay 2/3 of the premium.

Your Premium rate changes as You reach certain ages. The change will be effective January 1<sup>st</sup> of each year.

The State sets the premium and how much it pays. This can change. We will let You know in advance, if it changes.

## TERMINATION AND CONTINUATION OF COVERAGE

### A. Termination

You may terminate Your coverage at any time. If You terminate Your Coverage under this Plan, You will terminate from the CoverTN program. You will not be eligible to re-enroll in a CoverTN Plan for 6 months.

The State may terminate Your coverage if:

1. The terms and conditions of the CoverTN program change;
2. The CoverTN program terminates;
3. You move out of state and do not work for a Participating Employer; or
4. You die.

The Plan may terminate Your Coverage for cause, if:

1. The Plan does not receive the required Premium for Your Coverage when it is due. The fact that You have paid a Premium contribution to the Employer will not prevent the Plan from terminating your Coverage if the Employer fails to submit the full Premium for Your coverage to the Plan when due, or
2. You fail to make a required Member Payment; or
3. You fail to comply with the Plan provisions; or
4. You have made a material misrepresentation or committed fraud against the Plan. This includes, but is not limited to, furnishing incorrect or misleading information or permitting the improper use of the membership ID card.

Except in the case of death, You will be given a 30 day notice. Termination will be effective on the last day of the calendar month following the month of notice.

### B. Right To Request A Hearing

You may appeal the termination of Your Coverage for cause, as explained in the Grievance Procedure section of this MH. The fact that You have appealed shall not postpone or prevent the Plan from terminating Your Coverage. If Your Coverage is reinstated as part of the Grievance Procedure, You may submit any claims for services rendered after Your Coverage was terminated to the Plan for consideration, in accordance with the "Claims Procedure" section of this MH.

### C. Payment For Services Rendered After Termination of Coverage

Services received after Coverage terminates are not Covered, even if those services are part of a series of treatments that started before Coverage terminated. If You receive Covered Services after the Coverage terminated, the Plan, the Provider who rendered those services, or the Employer, may recover any charges for such services from You, plus any costs of recovering such charges, including attorney's fees.

### D. Continuation of Coverage

You and Your spouse may continue Coverage if :

1. You leave employment with the Participating Employer; or
2. Your Employer stops being a part of the CoverTN program.

You will be required to pay the Employer portion of the premium in addition to the Member portion.

If Your Coverage terminates due to non-payment of premium by the Employer, You have the option to pay the Employer's share within 60 days of notice to retain Coverage.

## 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 membership, 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 which 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 Member 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 for inpatient services received outside Tennessee.*

*If Prior Authorization is not received, Your benefits will be 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.*

## CLAIMS AND PAYMENT

When You receive Covered Services, either You or the Provider must submit a claim form to the Plan. We will review the claim, and let You, or the Provider, know if We need more information, before We pay or deny the claim.

### A. Claims.

Federal regulations use 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 You. Only post-service claims can be billed to the Plan, or You.
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. Until You reach Your benefit maximum, 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 will be charged or billed by an Out-of-Network Provider for Services rendered by that Provider. If You use an Out-of-Network Provider, You are responsible for all charges.
3. If you obtain services from an Out-of-Network Provider in the event of a true emergency, the Out-of-Network Provider may or may not file a claim for You. If You are charged or receive a bill, You must submit a claim to be considered for benefits. You must submit the claim within 1 year and 90 days from the date the service was received. If You do not submit the claim within 1 year and 90 days, it will not be considered. If it is not reasonably possible to submit the claim within 1 year and 90 days, it will not be invalidated or reduced.
4. A Network Provider may refuse to render a service, 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 the Plan 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 15 days. We may request additional information or documentation if it is reasonably necessary to make a Coverage decision concerning a claim.

**C. Payment**

1. When You receive Covered Services from a Network Provider, We pay the Network Provider directly. These payments are made according to the Plan's agreement with that Network Provider. You authorize assignment of benefits to that Network Provider.
2. If You received Covered Services from an Out-of-Network Provider, You are responsible for the full payment of the Out-of-Network Provider's charge.
3. We will pay benefits within 30 days after we receive a claim form that is complete. Claims are processed in accordance with current industry standards, and based on Our information at the time We receive the claim form.
4. When a claim is paid or denied, in whole or part, You will receive an Explanation of Benefits (EOB). This will describe how much was paid to the Provider, and also let You know if You owe an additional amount to that Provider. The EOB will show the status of Your benefit limits. For example, it will show how much of Your annual benefit remains, or how many visits remain. The Plan will send the EOB to the last address on file for You.
5. You are responsible for paying any applicable Copayment amount to the Provider.

Payment for Covered Services is more fully described in Attachment C: Schedule of Benefits.

**D. Complete Information**

Whenever You need to file a claim Yourself, We can process it for You 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  
PO Box 180150  
Chattanooga, Tennessee 37401-7150

## MEDICAL POLICY AND MEDICAL MANAGEMENT

### A. Introduction

Our health care services department performs various medical management functions that affect Your Coverage. Such services include Prior Authorization of certain services, concurrent review of hospitalization, discharge planning, lifestyle and health counseling, care coordination, and catastrophic medical case management. The Plan does not make medical treatment decisions under any circumstances. You may always elect to receive services that do not comply with the Plan's medical management requirements, but such an election may affect the Coverage of such services.

### B. 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. These services must be able to improve the health of our Members.

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 technologies.

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. It is Our right to change or modify those policies without notice to Members.

Medical Policies sometimes define certain terms. If the definition of a term defined in a Medical Policy is different from a definition in this MH, Medical Policy controls. Our Medical Policy is on Our website ([www.BCBST.com](http://www.BCBST.com)).

### C. Care Management

Under the Care Management Program, the Plan will identify Members with potentially complicated medical needs, chronic illness and/or catastrophic illnesses or injuries that may be suited for alternative treatment plans. After evaluation of the Member's condition, the Plan may, at its sole discretion, determine that alternative treatment is Medically Necessary and Appropriate.

#### **Lifestyle & Health Counseling**

Lifestyle & health counseling is a self-directed program that includes: (1) 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. Members are identified as possible candidates for the lifestyle & health counseling program through data that indicates the Member has received services for a low-risk health condition that can be self-managed with educational materials and tools.

#### **Care Coordination**

Care coordination 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 certain populations; (2) emergency services management program; (3) transition of care program; and (4) condition-specific care coordination program.

### **Emerging Health Care Programs**

Care Management is continually evaluating emerging health care programs. These are processes that demonstrate potential improvement in access, quality, efficiency and Member satisfaction.

When an emerging health care program is approved by Us, services provided through the program are Covered, even though they may be normally excluded under the MH.

#### **D. Prior Authorization**

Prior Authorization is required for planned hospital stays, certain outpatient surgeries and certain Specialty Pharmacy Products. Call Our Member service department to find out which services require Prior Authorization.

If You received Covered Services from a BlueCard PPO Participating Provider, and that Provider does not comply with medical management programs, You may not be held harmless.

Network Providers in Tennessee are responsible for obtaining Prior Authorization for Covered Services. You will not be penalized for a Network Provider's failure to obtain a Prior Authorization.

Care Management services, emerging health care programs and alternative treatment plans will 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.

## COORDINATION OF BENEFITS

**This Plan does not Coordinate Benefits. If You have any other group or individual coverage, this Plan will pay secondary.**

## SUBROGATION AND RIGHT OF RECOVERY

The State has agreed that the Plan shall be subrogated to and/or have the right to recover amounts paid to provide Covered Services to Members for illnesses or injuries caused by third parties, including the right to recover the reasonable value of services rendered by Network Providers.

The Plan shall have first lien against any payment, judgment or settlement of any kind that a Member receives 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. The Plan may notify those parties of its lien without notice to or consent from those Members.

The Plan may enforce its rights of subrogation and recovery against, without limitation, any tortfeasors, other responsible third parties or against available insurance coverages, including underinsured or uninsured motorist coverages. Such actions may be based in tort, contract or other cause of action to the fullest extent permitted by law.

The State has agreed that Members shall be required to promptly notify the Plan if they are involved in an incident that gives rise to such rights for subrogation and recovery to enable the Plan to protect its rights under this section. Members are also required to cooperate with the Plan and to execute any documents that the Plan deems necessary to protect its rights under this section.

If a Member settles any claim or action without Our consent against any third party, that Member shall be deemed to have been made whole by the settlement and the Plan shall be entitled to immediately collect the present value of its rights as the first priority claim from the settlement fund. Any such proceeds of settlement or judgment shall be held in trust by the Member for the benefit of the Plan. The Plan shall also be entitled to recover reasonable attorneys' fees incurred in collecting proceeds held by the Member in such circumstances.

## **GRIEVANCE PROCEDURE**

### **I. INTRODUCTION**

Our Grievance procedure (the “Procedure”) is intended to provide a fair, quick and inexpensive method of resolving any and all Disputes with the Plan. Such Disputes include: any matters that cause You to be dissatisfied with any aspect of Your relationship with the Plan; any Adverse Benefit Determination concerning a Claim; or any other claim, controversy, or potential cause of action You may have against the Plan. 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 MH or other documents that You receive from Us (e.g. an explanation of benefits); or (3) to initiate a Grievance concerning a Dispute.

1. 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 the Contract and this MH. Any decision to award damages must be based upon the terms of the Contract and this MH.
2. The Procedure can only resolve Disputes that are subject to Our control.
3. 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 the Plan, however, to complain about any matter related to the quality or availability of services, or any other aspect of Your relationship with Providers.
4. This Procedure incorporates the definitions of: (1) Adverse Benefit Determination; (2) urgent care; and (3) pre-service and post-service claims (“Claims”), which are in the “CLAIMS AND CLAIM PAYMENT” section.

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.

- a. If a Provider does not render a service, 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 the Plan 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 the Plan 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.
  - b. Providers may also appeal an Adverse Benefit Determination through the Plan's Provider dispute resolution procedure.
  - c. A Plan 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 the Plan has rendered a final Adverse Benefit Determination in a matter being appealed through the Provider dispute resolution procedure.
5. You may request a form from the Plan to authorize another person to act on Your behalf concerning a Dispute.
  6. The Plan and You may agree to skip one or more of the steps of this Procedure if it will not help to resolve Our Dispute.
  7. Any Dispute will be resolved in accordance with applicable Tennessee or Federal laws and regulations, the Contract and this MH.

## **II. DESCRIPTION OF THE REVIEW PROCEDURES**

### **A. 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.

### **B. Grievance**

You must submit a written request asking the Plan 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 from the Plan or from the date of the event that is otherwise causing You to be dissatisfied with the Plan. If You do not initiate a Grievance within 180 days of when We issue an Adverse Benefit Determination, 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. The Plan will assign a Grievance coordinator to assist You throughout the Grievance process. That Grievance coordinator will not make determinations concerning Your Dispute.

#### **1. Grievance Hearing**

After the Plan has 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, the Plan 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 eligibility, benefit and/or claim determinations, pursuant to the Contract.

#### **2. 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. The Plan will send You a copy of such documentation or information, without charge, upon written request.

### **C. 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. The Plan's Member service department will explain how to begin a second level Grievance.

The Plan may require You to exhaust each step of this Procedure in any Dispute.

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.

#### **1. 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 time, date 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.
- (c) If You wish to bring a personal representative with You to the hearing, You must notify Us at least 5 days in advance and provide the name, address and telephone number of Your personal representative.

#### **2. 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
- (c) 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.

### **D. Independent Review of Medical Necessity Determinations**

If still not satisfied, and Your Grievance involves a Medical Necessity determination, You may request that the Dispute be submitted to a neutral third party, selected by the Plan, to independently review and resolve such Disputes. Any person involved in making a decision concerning Your Dispute will not be a voting member of the independent review panel or committee.

You must file a written request that the Dispute be submitted for independent review within ninety (90) days from the date that We issue the second level committee's decision.

Your decision concerning whether to request independent review has no effect on Your rights to any other benefits under the Plan. You will be required to pay fifty dollars (\$50) of the cost of the review organization's fee in Disputes. In either type of action, You will be responsible for any other costs that You incur to participate in the independent review process, including attorney's fees.

The Plan will submit the necessary information to the independent review entity within five (5) business days after receiving Your request for review. The Plan will provide copies of non-privileged information to You, upon request. The reviewer may also request additional medical information from You within five (5) days after receiving the information from the Plan. You must submit any requested information, or explain why that information is not being submitted, within five (5) business days after receiving that request from the reviewer.

The reviewer must submit a written determination to the Plan and You within thirty (30) days after receipt of the independent review request. In the case of a life threatening condition, the decision must be issued within five (5) days after receiving the review request. The reviewer may request an extension of up to five (5) business days to issue a determination to consider additional information submitted by the Plan or You.

The reviewer's decision must state the reasons for the determination based upon: (1) the terms of this MH and the Contract; (2) Your medical condition; and (3) information submitted to the reviewer. The reviewer's decision may not expand the terms of Coverage of the Contract.

#### **E. Voluntary Arbitration**

If still not satisfied, You may request voluntary arbitration to resolve the Dispute. That arbitration request must be submitted, in writing, to the Plan's General Counsel within ninety (90) days after the independent reviewer's decision is issued.

A Dispute will be submitted to arbitration in accordance with applicable rules of the American Arbitration Association. Alternatively, the parties may agree to some other dispute resolution procedure or agency.

Your decision concerning whether to request arbitration will have no effect on Your rights to any other benefits under the Plan. Any person involved in making a decision concerning Your Dispute will not be permitted to serve as an arbitrator.

You will be required to pay one-half of the arbitration agency's and arbitrator (s)' fee in Disputes. In either type of action, You will be responsible for any other costs that You incur to participate in the arbitration process, including attorney's fees.

The arbitrator(s) shall be required to issue a reasoned written decision explaining the basis of that decision, and the manner of calculating any award. The arbitrator's decision is final and may be entered and enforced in any state or federal court. That decision may only be vacated modified or corrected for the reasons set forth in section 10 or 11 of the United States Arbitration Act (i.e., if the award contains material errors of law or is arbitrary and capricious).

<p>No action at law or in equity shall be brought to recover on this MH until 60 days after written proof of loss has been furnished as required by this MH. No such action shall be brought beyond 3 years after the time written proof of loss is required to be furnished.</p>
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## DEFINITIONS

Defined terms are capitalized. When defined words are used in this MH, they have the meaning set forth in this section. Words that are defined in the Plan's Medical Policies and Procedures have the same meaning if used in this MH.

1. **Acute** - An illness or injury which is both severe and of short duration.
2. **Annual Maximum** – The maximum amount of benefits for Covered Services rendered to You during a Calendar Year while Covered by the Plan.
3. **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.
4. **Billed Charges** – The amount that a Provider charges for services rendered. Billed Charges may be different from the amount that BCBST determines to be the Maximum Allowable Charge for services.
5. **BlueCard PPO Participating Provider** – A physician, hospital, licensed skilled nursing facility, home health care provider or other Provider contracted with other BlueCross and/or BlueShield Plans, Blue Card PPO Plans and/or Authorized by the Plan to provide Covered Services to Members.
6. **Brand Name Drug** - a Prescription Drug identified by its registered trademark or product name given by its manufacturer, labeler or distributor.
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. **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
10. **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 which contains at least one ingredient classified as a Legend Prescription Drug.
11. **Concurrent Review Process** – The process of evaluating care during the period when Covered Services are being rendered.
12. **Congenital Anomaly** – A physical developmental defect present at birth and identified within the first 12 months following birth.

13. **Copayment/Copay** – The dollar amount specified in Attachment C: Schedule of Benefits, that You are required to pay directly to a Provider for certain Covered Services. You must pay such Copayments at the time You receive those Services.
14. **Cosmetic Surgery** – Any treatment intended to improve Your 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 MH, (which is incorporated by reference). Covered Services are subject to all the terms, conditions, exclusions and limitations of the Contract and this MH.
16. **Custodial Care** - Any services or supplies provided to assist an individual in the activities of daily living as determined by the Plan including but not limited to eating, bathing, dressing or other self care activities.
17. **Drug Copayment/Copay** - the dollar amount that You must pay directly to the Network Pharmacy at the time the covered Prescription Drug is dispensed. The Drug Copayment must be paid for each Prescription Drug.
18. **Drug Formulary** - a list designating which Prescription Drugs and drug products are approved for reimbursement. This list is subject to periodic review and modification by the Plan.
19. **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:
  - a. serious impairment of bodily functions; or
  - b. serious dysfunction of any bodily organ or part; or
  - c. placing the prudent layperson’s health in serious jeopardy.

Examples of Emergency conditions include: (1) severe chest pain; (2) uncontrollable bleeding; or (3) unconsciousness.
20. **Emergency Care Services** - Those services and supplies that are Medically Necessary and Appropriate in the treatment of an Emergency.
21. **Employee** - A person who fulfills all eligibility requirements established by the State and the Plan.
22. **Employer** – A corporation, partnership, or sole proprietorship that is eligible to participate in the CoverTN program
23. **Enrollment Form** – A form or application, which must be completed in full by the eligible Employee before he/she will be considered for Coverage under the Plan.
24. **Experimental and/or Investigational Drugs** – Drugs or medicines, which are labeled: “Caution – limited by federal law to Investigational use.”
25. **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.
26. **Hospital Confinement or Hospital Admission** – When You are treated as a registered bed patient at a Hospital or other Provider facility and incur a room and board charge.

27. **Hospital Services** - Covered Services which are Medically Appropriate to be provided by an Acute care hospital.
28. **Investigational Service** - 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 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 shall not be the sole basis for denial), or
  - d. is being provided according to a written protocol which describes among its objectives, determining the safety, toxicity, efficacy or effectiveness of that service or supply in comparison with convention 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. The Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research within HHS has determined that the service or supply is either experimental or investigational or that there is insufficient data to determine if it is clinically acceptable, or
  - g. in the predominant opinion of experts, as expressed in the published authoritative literature, that usage should be substantially confined to research settings, or
  - h. in the predominant opinion of experts, as expressed in the published authoritative literature, further research is necessary in order to define safety, toxicity, efficacy, or effectiveness of that Service compared with conventional alternatives, or
  - i. 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:

- (1) Your medical records, or
- (2) the protocol(s) under which proposed service or supply is to be delivered, or
- (3) any consent document that You have executed or will be asked to execute, in order to receive the proposed service or supply, or
- (4) 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 You, or
- (5) regulations and other official publications issued by the FDA and HHS, or

- (6) the opinions of any entities that contract with the Plan to assess and coordinate the treatment of Members requiring non-Experimental or Investigational Services, or
  - (7) the findings of the BlueCross and BlueShield Association Technology Evaluation Center or other similar qualified evaluation entities.
29. **Late Enrollee** – An Employee or his or her spouse who fails to apply for Coverage within: (1) 30 days after such person first became eligible for Coverage under this MH; or (2) within a subsequent Open Enrollment period.
  30. **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.”
  31. **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.
  32. **Maintenance Drug** – Prescription Drugs most commonly used for selected disease states that are considered long term, chronic, and stable. The Plan maintains a list of Maintenance Drugs, which is reviewed periodically by Our Pharmacy and Therapeutics Committee. In keeping with accepted standards of medical practice, not all therapeutic classes of Drugs are included on the Maintenance Drug list.
  33. **Maximum Allowable Charge** – The amount that the Plan, at its sole discretion, has determined to be the maximum amount payable for a Covered Service. That determination will be based upon the Plan’s contract with a Network Provider for Covered Services rendered by that Provider.
  34. **Medical Director** - The physician designated by the Plan, or that physician’s designee, who is responsible for the administration of the Plan’s medical management programs, including its authorization program.
  35. **Medically Appropriate** – Services, which have been determined by the Medical Director of the Plan 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.
36. **Medically Necessary or Medical Necessity** – Services which have been determined by the Plan to be of proven value for use in the general population. To be Medically Necessary a service must:
- a. have final approval from the appropriate government regulatory bodies;
  - b. have scientific evidence permitting conclusions concerning the beneficial effect of the service on health outcomes;
  - c. improve the net health outcome;
  - d. be as beneficial as any established alternative;
  - e. demonstrate the improvement outside the investigational setting; and
  - f. not be an experimental or Investigational service.
37. **Medicare** - Title XVIII of the Social Security Act, as amended, and coverage under this program.
38. **Member, You, Your** - An Eligible Employee or his or her spouse enrolled through the Plan under the CoverTN program...
39. **Member Payment** – The Copayment amounts for Covered Services that You are responsible for as set forth in Attachment C: Schedule of Benefits. The Plan may require proof that You have made any required Member Payment.
40. **Network Benefit** – The Plan's payment level that applies to Covered Services received from a Network Provider. See Attachment C: Schedule of Benefits.
41. **Network Pharmacy** - A Pharmacy which has entered into a Participating Pharmacy Agreement with BCBST or its agent to provide Prescription Drug benefits to Members Covered under this MH, either in person or through home delivery.
42. **Network Provider** - A Provider who has contracted with the Plan to provide access to benefits to Members at specified rates. Such Providers may be referred to as Blue Card PPO Participating Providers, Participating Hospitals, etc.
43. **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. A Non-Contracted Provider is different from an Out-of-Network Provider. A Non-Contracted Provider is not eligible to hold a contract with the Plan. Provider types that are considered Non-Contracted can change as We contract with different Provider types. 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.
44. **Non-Participating Employer** – An Employer who does not qualify for CoverTN or qualifies for CoverTN but chooses not to participate.
45. **Non-Routine Diagnostic Services** – Services listed under non-routine diagnostic services in Attachment A: Covered Services.

46. **Open Enrollment Period** - Those periods of time agreed to by the Plan and the State during which eligible Employees and their spouses may enroll as Members. The Open Enrollment period for the State's CoverTN program is the month of October.
47. **Out-of-Network Pharmacy** - A Pharmacy which has not entered into a service agreement with BCBST or its agent to provide benefits under this MH at specified rates to Members Covered under this MH.
48. **Out-of-Network Provider** – Any Provider who is an eligible Provider type but who does not have a contract with the Plan to provide Covered Services.
49. **Participating Employer** – An Employer who qualifies for CoverTN and chooses to participate in CoverTN.
50. **Participating Employer Agreement** – The arrangement between the Plan and the Participating Employer.
51. **Payor(s)** - An insurer, health maintenance organization, no-fault liability insurer, self-insured group, or other entity that provides or pays for a Member's health care benefits.
52. **Periodic Health Screening** – An assessment of a patient's health status at intervals set forth in the Plan's Medical Policies, for the purpose of maintaining health and detecting disease in its early state. This assessment should include:
  - a. 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 the Plan's Medical Policy.
53. **Pharmacy** - a state or federally licensed establishment which 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.
54. **Pharmacy and Therapeutics Committee or P&T Committee** - A panel of the Plan's participating pharmacists, Network Providers, medical directors and pharmacy directors which reviews medications for safety, efficacy and cost effectiveness. The P&T Committee evaluates medications for addition and deletion from the: 1) Drug Formulary; 2) Maintenance Drug list; and 3) Quantity Limitation list. The P&T Committee may also set dispensing limits on medications.
55. **Practitioner** – A person licensed by the State to provide medical services.
56. **Pre-existing Condition** – Any physical or mental condition, regardless of cause, which was present during the six month period immediately before the earlier of when Your Coverage became effective under this MH, or the first day of any Pre-Existing Condition Waiting Period, for which medical advice, diagnosis, care or treatment was recommended or received from a Provider of health care services.

The following are not Pre-Existing Conditions:

- a. Genetic information in the absence of a diagnosis of the condition related to the genetic information; and
  - b. Pregnancy.
57. **Pre-existing Condition Waiting Period** – The 12 month period which begins on the date Your Coverage became effective, and during which benefits are not available for services received in connection with a Pre-existing Condition. You will be responsible for all

charges for services received for a Pre-existing Condition during the Pre-existing Condition Waiting Period.

58. **Premium** – The total payment for Coverage under the Contract, including amounts paid by You and the Employer for such Coverage.
59. **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.
60. **Prescription Drug** - a medication containing at least one Legend Drug which may not be dispensed under applicable state or federal law without a Prescription, and/or insulin.
61. **Prior Authorization, Authorized** – A review conducted by the Plan, prior to the delivery of certain services, to determine if such services will be considered Covered Services.
62. **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.
63. **Quantity Limitation** – Quantity limitations applied to certain Prescription Drug products as determined by the Pharmacy and Therapeutics Committee.
64. **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 Plan’s Specialty Pharmacy Products list. Specialty Pharmacy Products are categorized as provider-administered or self-administered.
65. **Totally Disabled or Total Disability** – Either: (a) You, if an Employee, are prevented from performing Your work duties and are unable to engage in any work or other gainful activity for which You are qualified or could reasonably become qualified to perform by reason of education, training, or experience because of injury or disease; or (b) You, if a Spouse, are prevented from engaging in substantially all of the normal activities of a person of like age and sex in good health because of non-occupational injury or disease.
66. **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.

## **IMPORTANT NOTICE FOR MASTECTOMY PATIENTS**

Patients who undergo a mastectomy, and who elect breast reconstruction in connection with the mastectomy, are entitled to coverage 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

in a manner determined in consultation with the attending physician and the patient. The coverage may be subject to copayments consistent with those established for other benefits. Please refer to the body of the MH for details

## **UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994**

You may continue Your Coverage during military leave of absence in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994. When You return to work from a military leave of absence, You will be given credit for the time You were Covered under CoverTN prior to the leave. Check with the Employer to see if this provision applies.

## **NOTICE REGARDING CERTIFICATES OF CREDITABLE COVERAGE**

This CoverTN Plan contains a Pre-Existing Condition Exclusion, which may limit Your Coverage. The Pre-Existing Condition Waiting Period for any Pre-Existing Condition may be reduced by the total amount of time You were covered by similar creditable health coverage, unless Your coverage was interrupted for more than 63 days. Periods of similar creditable health coverage prior to a break in coverage of 63 days or more shall not be deducted from the Pre-Existing Condition Waiting Period. Any period of time You had to wait to be eligible under an employer's plan is not considered an interruption of coverage.

You have the right to demonstrate the amount of Creditable Coverage You have, including any waiting periods that were applied before You became eligible for Coverage. For any period after July 1, 1996, You can ask a plan sponsor, health insurer or HMO to provide You with a "certification form" documenting the periods during which You had health benefit coverage. If You are having trouble obtaining documentation of Your prior Creditable Coverage, You may contact the CoverTN Plan for assistance in obtaining documentation of prior Creditable Coverage from any prior plan or issuer.

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

The Plan will 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: Schedule of Benefits of this MH, which is incorporated herein by reference. 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 the Plan's Medical Policies and procedures. (See 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 set by the Plan for Covered Services. Maximum Allowable Charge is what the Plan has agreed, by a contract, to pay these Providers for Covered Services. (See the Definitions section for an explanation of Maximum Allowable Charge and Covered Services.) Network Providers have also agreed not to bill You for amount above these Maximum Allowable Charge.**

**If you need help finding a provider and/or scheduling an appointment,  
please call: 1-888-887-3224.**

**Out-of-Network Providers do not have a contract with the Plan. This means they will be able to charge You more than the amount set by the Plan in its contracts. With Out-of-Network Providers, You will be responsible for the full amount that You are charged.**

**Obtaining services not listed in this Attachment or not in accordance with the Plan's Medical Management Policies and Procedures may result in the denial of payment. Obtaining Prior Authorization is not a guarantee of Coverage. All provisions of the MH must be satisfied before Coverage for services will be rendered. The Plan's Medical Policies can help Your Provider determine if a proposed service will be Covered.**

**Covered Services have annual limits.  
Please refer to Attachment C: Schedule of Benefits for these limits.**

**I. ELIGIBLE PROVIDERS OF SERVICE**

**A. Practitioners**

All services must be rendered by a Practitioner listed in the Directory of Network Providers. 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. Other Providers of Service**

An individual or facility, other than a Practitioner, duly licensed to provide Covered Services and listed in the Directory of Network Providers.

**C. Out-of-Network Providers**

No benefits will be paid for services received from Out-of-Network providers under this plan. There are two exceptions to this:

1. You do have benefits for Out-of Network, hospital based Practitioners in a Network facility, but only up to the Maximum Allowable Charge for the services provided. If that Practitioner does not participate in Your Network, You will be responsible for any difference between the Maximum Allowable Charge and that Out-of-Network Practitioner's charges.
2. In a true Emergency, You have benefits for Out-of-Network Providers (Facility and Practitioners), but only up to the Maximum Allowable Charge. You will be responsible for any difference between the Maximum Allowable Charge and the Out-of-Network Provider's charges.

**II. ELIGIBLE SERVICES:**

**A. Practitioner Office Services**

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

1. Covered
  - a. 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.
  - b. Injections and medications administered in a Practitioner's office, except Specialty Pharmacy Products. (See Provider Administered Specialty Pharmacy Products section for information on Coverage).
  - c. Casts and dressings.
  - d. Nutritional guidance and education.
  - e. Foot care necessary to prevent the complications of an existing disease state.
  - f. Second surgical opinions given by a Practitioner who is not in the same medical group as the Practitioner who initially recommended surgery.
  - g. Emergency conditions presenting to the Practitioner's Office.
2. Exclusions
  - a. 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.
  - b. Routine foot care for the treatment of: 1) flat feet; 2) corns; 3) bunions; 4) calluses; 5) toenails; 6) fallen arches; and 7) weak feet or chronic foot strain.
  - c. Foot orthotics, shoe inserts and custom made shoes, except for diabetic patients or as a part of a leg brace.

- d. Rehabilitative therapies
- e. Pre and post-natal maternity care, including complications of pregnancy (except for initial diagnosis of a pregnancy).
- f. Non-routine diagnostics (including but not limited to MRIs, CT Scans, PET Scans).
- g. Allergy tests, injections and sera.

## **B. Preventive Services**

Medically Necessary and Appropriate services for assessing physical status and detecting abnormalities. The frequency of visits and services are based on the Plan's Medical Policy guidelines.

### 1. Covered

- a. One Well Woman Exam every Calendar Year, including any follow-up care. This visit includes mammogram and cervical cancer screening.
- b. Prostate cancer screening.
- c. A Well Care Exam every Calendar Year. This visit may include:
  - Blood pressure screening;
  - Periodic cholesterol screening;
  - 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.

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. Immunizations needed for foreign travel.
- b. 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.
- c. Non-routine diagnostics (including but not limited to MRIs, CT Scans, PET Scans)
- d. Preventive services not listed as Covered.
- e. Services not provided in accordance with the Plan's Medical Policy guidelines.

### **C. Office Surgery/Procedures**

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. Excision of skin lesions and incisions.
  - b. Repair of lacerations.
  - c. Removal of foreign bodies from skin, eyes, or orifices.
  - d. Sigmoidoscopy, pharyngoscopy, or other endoscopies.
  - e. Biopsies.
  - f. Colposcopy.
  - g. Incision and drainage of abscess.
  - h. Cyst aspiration.
  - i. Joint injection and aspiration.
  - j. Toenail excision.
  - k. Cryosurgery of skin lesions and cervical lesions.
  - l. Casting and splinting.
  - m. Vasectomy.
2. Exclusions
  - a. Dental procedures.
  - b. Colonoscopies.

### **D. Inpatient Hospital Services**

Medically Necessary and Appropriate services and supplies in a Hospital which: (1) is a licensed Acute care institution; (2) which 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 and provides 24 hour nursing care by graduate registered nurses. Psychiatric hospitals are not required to have a surgical facility.

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); general nursing care; medications, injections, diagnostic services and special care units.
  - b. Attending Practitioner's services for professional care.
  - c. Observation stays.
  - d. Blood/plasma is covered unless free.
2. Exclusions

- a. Inpatient stays primarily for therapy (such as physical or occupational therapy).
- b. Inpatient rehabilitation.
- c. Private duty nursing.
- d. Maternity and delivery services, including complications of pregnancy.
- e. Services that could be provided in a less intensive setting.
- f. Private room when not authorized by the Plan and room and board charges are in excess of semi-private room.

**E. Hospital Emergency Care Services**

Medically Necessary and Appropriate health care services and supplies furnished in a Hospital which are required to determine, evaluate and/or treat an Emergency until such condition is stabilized, as directed or ordered by the Practitioner or Hospital protocol. In the event of a true Emergency, benefits are available from an Out-of-Network Facility, up to the Maximum Allowable Charge. You will be responsible for any difference between the Maximum Allowable Charge and the Out-of-Network Facility's billed charges.

- 1. Covered
  - a. Medically Necessary and Appropriate Emergency services, supplies and medications necessary for the diagnosis and stabilization of Your Emergency condition.
  - b. Practitioner services.
- 2. Exclusions
  - a. Services received for inpatient care or transfer to another facility once Your medical condition has stabilized, unless Prior Authorization is obtained from the Plan within 24 hours or the next working day.

**F. Ambulance Services**

Medically Necessary and Appropriate land 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 You.

- 1. Covered
  - a. Medically Necessary and Appropriate land transportation from the scene of an accident or emergency to the nearest appropriate facility.
- 2. Exclusions
  - a. Air ambulance.
  - b. Transportation for Your convenience.
  - c. Transportation that is not essential to reduce the probability of harm to You.
  - d. Services when You are not transported to a facility.

**G. Outpatient Facility Services**

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

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. Observations stays.
2. Exclusions
  - a. Rehabilitative therapies.
  - b. Vasectomies.
  - c. Maternity and Delivery Services (including complications of pregnancy).
  - d. Services that could be provided in a less intensive setting.

#### **H. Behavioral Health**

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.

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) Two partial hospital days for 1 inpatient day.
    - (2) Three intensive outpatient program days for 1 inpatient day.
2. Exclusions
  - a. Medical detox when performed in a non-medical facility.
  - b. Residential treatment level of care for either psychiatric or substance abuse.
  - c. Pastoral counseling.
  - d. Marriage and family counseling without a behavioral health diagnosis.
  - e. Vocational and educational training and/or services.
  - f. Custodial or domiciliary care.
  - g. Services related to Mental Retardation, Learning Disorders or Developmental Disabilities, Disorders or Delays as described in the International Classification of Disease Manual (ICD)
  - h. Habilitative as opposed to rehabilitative services, i.e., services to achieve a level of functioning the individual has never attained.
  - i. Any care in lieu of legal involvement or incarceration.

- j. Hypnosis or regressive hypnotic techniques.
- k. Charges for telephone consultations, missed appointments, completion of forms, or other administrative services.
- l. Methadone maintenance therapy.
- m. Buprenorphine maintenance therapy.
- n. Any International Classification of Disease (ICD) codes that are not included in the code range from 290 to, and including, 314.9.

**I. Reconstructive Breast Surgery**

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

- 1. Covered
  - a. Reconstructive breast surgery as a result of a mastectomy (other than lumpectomy) including 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.
  - d. Any other reconstructive surgery.

**J. Diagnostic Services**

Medically Necessary and Appropriate diagnostic radiology services and laboratory tests.

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

**K. 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.

- 1. Covered
  - a. Provider-administered Specialty Pharmacy Products for the treatment of cancer, and identified on the CoverTN Plan's Specialty Pharmacy Products list (includes administration by a qualified provider).
- 2. Exclusions

- a. Self-administered Specialty Pharmacy Products as identified on the Plan's specialty pharmacy list.
- b. Other Provider-administered Specialty Pharmacy Products not used for the treatment of cancer and not included on the CoverTN Plan's Specialty Pharmacy Products List.

**L. Vision**

Medically Necessary and Appropriate diagnosis and treatment of diseases and injuries which 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 lens 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. Eye exercises and/or therapy.
  - d. Visual training.

**M. 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 and supplies.

- 1. Covered
  - a. Blood glucose monitors, as listed on the formulary. Test strips for blood glucose monitors, as listed on the formulary.
  - b. Insulin.
  - c. Syringes.
  - d. Lancets.
- 2. Exclusions
  - a. Visual reading and urine test strips.
  - b. Injection aids.
  - c. Insulin pumps, infusion devices and appurtenances.
  - d. Oral hypoglycemic agents.
  - e. Glucagon emergency kits.
  - f. Treatments or supplies that are not prescribed and certified by a Practitioner as being Medically Necessary.

- g. Outpatient self-management training and education, including medical nutrition counseling.
- h. Podiatric appliances.

**N. Home Health Care Services**

Medically Necessary and Appropriate services and supplies provided in Your home by a Practitioner who is primarily engaged in providing home health care services.

1. Covered
  - a. Part-time, intermittent health services, supplies, and medications, by or under the supervision of a registered nurse.
  - b. Home infusion therapy.
  - c. Coverage is limited as indicated in Attachment C: Schedule of Benefits.
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 Care or Custodial Care; (6) social casework; (7) meal delivery; (8) personal hygiene; and (10) convenience items.
  - b. Rehabilitative therapies such as physical therapy, occupational therapy, etc.
  - c. Medical social services.
  - d. Dietary guidance.
  - e. Services that were not Authorized by the Plan.

**O. Hospice**

Medically Necessary and Appropriate services and supplies for supportive care where 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.

**P. Prescription Drug Program**

**Formulary generic prescription drugs and insulin prescribed when You are not confined in a hospital or other facility.**

**BENEFITS FOR PRESCRIPTION DRUGS**

Generic Drugs: \$8 Drug Copayment per Prescription per 30 day supply  
 Brand Drugs (Limited to Insulin and test strips): \$10 Drug Copayment per Prescription per 30 day supply

**Prescription Drugs are subject to a Calendar Quarter Benefit Maximum of: \$75**

**Diabetic drugs and supplies do not count toward the Calendar Quarter Benefit Maximum**

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

Your Copayments vary based on the days supply dispensed, as shown below:

	One month supply (Up to 30days)	Two months supply (31 to 60 days)	Three months supply (61 to 90 days)
	Generic/Brand Drug	Generic/Brand Drug	Generic/Brand Drug
Retail network up to 30 days	\$8/\$10	N/A	N/A
Home delivery network	\$8/\$10	\$16/\$20	\$24/\$30
Out-of-Network	Not Covered		

Brand Drugs are limited to Insulin and test strips.

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

The Drug Benefit Maximum amounts do not apply to satisfying any other Benefit Maximum amounts in the Plan.

If You have a Prescription filled at an Out-of-Network Pharmacy, that Prescription will not be covered under this MH.

## 1. COVERED SERVICES

- a. Prescription Drugs prescribed when You are not confined in a hospital or other facility. Prescription Drugs must be:
  - (1) prescribed on or after Your Coverage begins;
  - (2) approved for use by the Food and Drug Administration (FDA);
  - (3) dispensed by a licensed pharmacist or Participating physician;
  - (4) listed on the closed Drug Formulary; and
  - (5) not available for purchase without a 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. The Plan has time limits on how soon a Prescription can be refilled. If You request a refill too soon, the Network Pharmacy will advise You when Your Prescription benefit will Cover the refill.
- c. Prescription and non-Prescription medical supplies, devices and appliances are not Covered, except for syringes or other supplies used in the treatment of diabetes;
- d. Prescription Drugs which are commercially packaged or commonly dispensed in quantities less than a 30-calendar day supply (e.g. prescription items which 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.
- e. The Plan does not Cover Prescription Drugs prescribed for purposes other than for:
  - (1) indications approved by the FDA; or
  - (2) off-label indications recognized through peer-reviewed medical literature.

### 3. EXCLUSIONS

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

- a. drugs which are prescribed, dispensed or intended for use while You are confined in a hospital, skilled nursing facility or similar facility, except as otherwise Covered in the MH;
- 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 this MH;
- c. any quantity of Prescription Drugs which exceed that specified by the Plan's 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. non-medical supplies or substances, including support garments, regardless of their intended use;
- g. any drugs or medicines dispensed more than one year following the date of the Prescription;
- h. Prescription Drugs You are entitled to receive without charge in accordance with any worker's compensation laws or any municipal, state, or federal program;
- i. replacement Prescriptions resulting from lost, spilled, stolen, or misplaced medications (except as required by applicable law);
- j. drugs dispensed by a Provider other than a Pharmacy;
- k. administration or injection of any drugs;
- l. Prescription Drugs not on the Drug Formulary;
- m. 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;

- n. Compound drugs;
- o. Experimental and/or Investigational Drugs;
- p. Brand Name Drugs, except insulin;
- q. Prescription Drugs obtained from an Out-of-Network Pharmacy;
- r. Provider-administered Specialty Pharmacy Products, as indicated on Our Specialty Pharmacy Products list, except as otherwise Covered in this MH.
- s. Prescription Drugs or refills dispensed:
  - (1) in quantities in excess of amounts specified in the BENEFIT PAYMENT section;  
or
  - (2) which exceed any applicable Annual Maximum Benefit, or any other maximum benefit amounts stated in this MH.

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

**ATTACHMENT B:  
EXCLUSIONS FROM COVERAGE**

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

1. Services or supplies not listed as Covered Services under Attachment A, Covered Service.
2. Services or supplies that are determined to be not Medically Necessary and Appropriate or have not been authorized by the Plan.
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 Your needs, We reserve the right to provide payment for the least expensive Covered Service alternative.
5. Illness or injury resulting from war, which occurred before Your Coverage began under this MH and which is Covered by: (1) veteran's benefit; or (2) other coverage for which You are legally entitled.
6. Self treatment or training.
7. Staff consultations required by hospital or other facility rules.
8. Services which are free.
9. Services or supplies for the treatment of illness or injury related to Your 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 of a Covered Employee who is (1) a sole-proprietor of the Employer; (2) a partner of the Employer; or (3) a corporate officer of the Employer, provided the officer filed an election not to accept Workers' Compensation with the appropriate government department.
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; (12) tanning beds, (13) weight loss programs; (14) physical fitness programs; or (15) self-help devices which are not primarily medical in nature, even if ordered by a Practitioner.
12. Services or supplies received before Your effective date for Coverage with this Plan.
13. Services or supplies related to a Hospital Confinement, received before Your effective date for Coverage with this Plan.
14. Services or supplies received after Your Coverage under this Plan ceases for any reason. This is true even though the expenses relate to a condition that began while You were Covered.
15. Services or supplies received in a dental or medical department maintained by or on behalf of the employer, mutual benefit association, labor union or similar group.
16. 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.
17. Services for providing requested medical information or completing forms. We will not charge You or Your legal representative for statutorily required copying charges.

18. Court ordered examinations and treatment, unless Medically Necessary.
19. Room, board and general nursing care rendered on the date of discharge, unless admission and discharge occur on the same day.
20. Benefits for Pre-existing Conditions are excluded until the Pre-existing Condition Waiting Periods have been met. Refer to Pre-existing Condition Waiting Period in Attachment C: Schedule of Benefits.
21. Charges in excess of the Maximum Allowable Charge for Covered Services or any charges which exceed the individual benefit limits or the Annual Maximum.
22. Any service stated in the Attachment A as a non-Covered Service or limitation.
23. Charges for services performed by You or Your spouse, or Your or Your spouse's parent, sister, brother or child.
24. Any charges for handling fees.
25. Nicotine replacement therapy and aids to smoking cessation including, but not limited to, patches.
26. Safety items, or items to affect performance primarily in sports-related activities.
27. Services or supplies related to obesity, including surgical or other treatment of morbid obesity;
28. Services or supplies related to treatment of complications 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 has been determined to be Medically Necessary, including leaving an inpatient medical facility against the advice of the treating physician.
29. 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.
30. 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.
31. Services and charges related to the care of the biological mother of an adopted child, if the biological mother is not a Member. Services and charges relating to surrogate parenting.
32. Sperm preservation.
33. Services or supplies for orthognathic surgery.
34. Services or supplies for Maintenance Care.
35. Private duty nursing.
36. Pharmacogenetic testing.
37. Services or supplies to treat sexual dysfunction, regardless of cause, including but not limited to erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido.
38. Removal of impacted teeth, including wisdom teeth.
39. Services or supplies for methadone maintenance therapy and buprenorphine maintenance therapy.
40. Cranial orthosis, including helmet or headband, for the treatment of plagiocephaly.

41. Pre and post-natal maternity care, including complications of pregnancy. Benefits may be available under the CoverKids program.
42. Allergy tests, injections and sera.
43. Inpatient Rehabilitation.
44. Family planning services and those services to diagnose and treat diseases which may adversely affect fertility.
45. Surgery to correct significant defects from congenital causes, accidents or disfigurement from a disease state.
46. Skilled Nursing Facility Services.
47. Therapeutic and Rehabilitative Services.
48. Organ Transplants.
49. Dental Services.
50. Services to diagnose and treat temporomandibular joint syndrome or dysfunction.
51. Provider-administered Specialty Pharmacy Products, except those specifically included in Attachment A, Covered Services.
52. Orthotics.
53. Durable Medical Equipment.
54. Prosthetics.
55. Medical Supplies.

**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 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.

<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 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

<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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**Services Received at a Facility**  
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.

**Inpatient Hospital Stays**  
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 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 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	Limited to two (2) non-surgical outpatient visits and one (1) surgical outpatient visit 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 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

<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 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

<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 two (2) 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>		
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<p>Prescription Formulary Generic Drugs</p> <p>Benefits for Generic Drugs are limited to the Generic Drugs listed on the CoverTN Formulary.</p>	<p>100% after \$8 Copay per 30 day supply</p>	<p>Subject to Calendar Quarterly payment limit of \$75.</p> <p>Unused benefits do not accumulate towards the next Calendar Quarter.</p> <p>Generic drugs purchased from an Out-of-Network Pharmacy are not Covered.</p>
<p>Prescription Formulary Brand Drugs</p> <p>Benefits for Brand Drugs are limited to Insulin and the Diabetic Supplies listed on the CoverTN Formulary.</p>	<p>100% after \$10 Copay per 30 day supply</p>	<p>Not subject to Calendar Quarterly payment limit of \$75.</p> <p>Brand drugs purchased from an Out-of-Network Pharmacy are not Covered.</p>

<b>Diabetic Supplies</b>		
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Blood Glucose Monitors	100%	Not subject to Calendar Quarterly payment limit of \$75
Blood Glucose Test Strips	100% after \$10 copay	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

## 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 all Members; inform Members of the Plan’s legal obligations; and advise Members of additional rights concerning their medical information. The Plan must follow the privacy practices contained in this notice from its effective date of April 14, 2003, until this notice is changed or replaced.

The Plan reserves the right to change privacy practices and the terms of this notice at any time, as permitted by the Plan’s 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 Members will be notified of any changes by receiving a new notice of the Plan’s 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.

#### **A. 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 the Plan’s Members may be shared with each other as needed for treatment, payment or health care operations.

#### **B. 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.

**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 the Plan may do so, as described in the Individual Rights section of this notice below.

**PLAN SPONSORS:** Your medical information and the medical information of others enrolled in Your health plan may be disclosed to Your plan sponsor in order to perform plan administration

functions. Please see Your plan documents for a full description of the uses and disclosures the plan sponsor may make of Your medical information in such circumstances.

**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 the Plan does 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:** The Plan's 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.

### **C. 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 the Plan's cost of providing Your medical information in that format. If You prefer, the Plan 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. The Plan 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 the Plan 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 disclosed 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 the Plan's use or disclosure of Your medical information the Plan is not required to agree to such requests. **The Plan 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 the Plan communicates 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.** The Plan 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 the Plan amends Your medical information. **Your request must explain why the information should be amended.** The Plan may deny Your request if the medical information You seek to amend was not created by the Plan or for other reasons permitted by the Plan's legal obligations. If Your request is denied, the Plan 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 the Plan accepts Your request, the Plan 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.

#### **D. QUESTIONS AND COMPLAINTS**

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

If:

1. You are concerned that the Plan has violated Your privacy rights; or
  - a. 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
  - b. You wish to request the Plan 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. The Plan 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) 535-1976 FAX  
Privacy\_office@bcbst.com**



**of Tennessee**

[bcbst.com](http://bcbst.com)

One Cameron Hill Circle  
Chattanooga, TN 37402

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association  
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Hablemos español or another language? For more information about alternative formats and interpreter services, call 1-888-987-3224. 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 Administration, 26th Floor WRS Tennessee Tower, 312 9th Ave. N., Nashville, TN 37243.  
This document has been classified as public information.