

HealthyTNBabies Member Handbook
2012



Call 1-888-325-8386, toll free, Monday-Friday, 8 a.m.-6 p.m., ET, if you need help or need to speak with someone in another language. TDD/TTY users should call 1-866-591-2908. These services are free to enrollees. We do not allow unfair treatment in CoverKids. No one is treated in a different way because of race, color, birthplace, religion, language, sex, age, or disability. Do you think you've been treated unfairly? Do you have more questions or need more help? If you think you've been treated unfairly, call the Office of Non-Discrimination for free at 1-855-286-9085.

HEALTHYTNBABIES MEMBER HANDBOOK

NOTICE

PLEASE READ THIS MEMBER HANDBOOK CAREFULLY AND KEEP IT IN A SAFE PLACE FOR FUTURE REFERENCE. IT EXPLAINS YOUR COVERAGE THROUGH HEALTHYTNBABIES. 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:

**HEALTHYTNBABIES MEMBER SERVICE DEPARTMENT
BLUECROSS BLUESHIELD OF TENNESSEE, INC.
1 CAMERON HILL CIRCLE
CHATTANOOGA, TENNESSEE 37402-2555
(888) 325-8386
(866) 591-2908 TTY/TDD**

IF YOU HAVE ANY QUESTIONS ABOUT ELIGIBILITY IN THE PLAN WRITE OR CALL THE STATE'S ELIGIBILITY CONTRACTOR AT:

**COVERKIDS HEALTHYTNBABIES
P.O. BOX 182261
CHATTANOOGA, TN 37422-7261
(866) 620-8864
(866) 447-0272 TTY
(866) 913-1046 FAX**

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INTRODUCTION

This Member Handbook describes the terms and conditions of Your Coverage. “You”, “Your” and “Member” mean the person eligible and enrolled for benefits under the CoverKids HealthyTNBabies program (“Plan”). “We”, “Us” and “Our” mean BlueCross BlueShield of Tennessee, Inc. (BCBST), the administrator of the Plan. “Coverage” means the benefits Members are entitled to receive under this Plan. The State’s Coverage for maternity is under the CoverKids program and is called HealthyTNBabies. This Member Handbook describes the terms and conditions of Your Coverage from the Plan through the State. This Member handbook replaces and supercedes any Evidence of Coverage (EOC) or Member Handbook that You have previously received from the Plan.

PLEASE READ THIS MEMBER HANDBOOK CAREFULLY. It describes Your rights and duties as a Member. It is important to read the entire Member Handbook. 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-C.)

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

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

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

The State of Tennessee (“State”) has entered into a Contract (“Contract”) with Us for Us to perform administrative services for the Plan. Such services include network contracting, customer service, claims payment and utilization review and clinical management. We do not assume any financial risk or obligation with respect to Plan claims. We are not the plan sponsor, the plan administrator or the plan fiduciary. We are the claims administrator. The State is the plan fiduciary, the plan sponsor and the plan administrator. The Plan will also be using Our Provider Networks.

In addition to Us, the Plan may have other contractors provide additional administrative services for it. These contractors will perform services in a manner consistent with this Member Handbook.

While the State has delegated discretionary authority to make any benefit or eligibility determinations to Us, the State also has the authority to make any final Plan determination. Both We and the State, as the plan administrator, also have the authority to construe the terms of Your Coverage. We shall be deemed to have properly exercised that authority unless either party has abused its discretion when making such determinations.

WHAT IS A PPO PLAN?

Our 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. You are responsible for all charges from an Out-of-Network Provider. Attachment C: Schedule of Benefits, shows 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. Your membership ID card is the key to receiving the benefits of the Plan. Carry it at all times.

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

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

Important: Your membership ID card 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 medical care and Prescription medicines.
2. Always use Network Providers, including pharmacies, durable medical equipment suppliers 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, 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/Providers/Administration/Manuals.
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 Member Handbook.) 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. Get a second opinion before undergoing elective services.
10. Notify the State's Eligibility Contractor toll-free at (866) 620-8864 if changes in the following occur:
 - a. Name.
 - b. Address.
 - c. Telephone number.
 - d. Employment.
 - e. Status of any other health insurance You might have.
 - f. Marriage.
 - g. Death.
11. There are many community resources that may be helpful to You. For information, please call the Member service number shown on Your membership ID card or visit Our web site at www.BCBST.com.

Benefit Administration Error

If We make an error in administering the benefits under this Plan, the Plan may provide additional benefits or recover any overpayments from any person, insurance company, or plan. No such error may be used to demand more benefits than those otherwise due under this Plan. No such error is a guarantee of continued benefits that were provided in error.

RELATIONSHIP WITH NETWORK PROVIDERS

A. Independent Contractors

Network Providers are not employees, agents or representatives of the Plan or Us. Such Providers contract with Us and We have 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. Network Providers are not Our employees, agents or representatives.

The Plan has given Us the discretionary authority to make benefit determinations and interpret the terms of Your Coverage under this Plan (“Coverage Decisions”). We make those Coverage Decisions based on the terms of this Member Handbook, the State’s Contract with Us, Our participation agreements with Network Providers and applicable State or Federal laws.

The Network Providers’ 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 Member Handbook. The participation agreement requires Network Providers to fully and fairly explain Coverage decisions to You, upon request, if You decide to request that We reconsider a Coverage decision.

We have 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 Member service department.

B. Termination of Provider’s Participation

We or a Network Provider may end Our 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. We do not promise that any specific Network Provider will be available to render services while You are Covered by this Plan.

INDEPENDENT LICENSEE OF THE BLUECROSS BLUESHIELD ASSOCIATION

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

ELIGIBILITY

Pregnant women, who meet the requirements of the HealthyTNBabies program, are eligible for Coverage if enrolled. If there is a question about whether a person is eligible for Coverage, the State or the State's Eligibility Contractor shall make the final determination. To be eligible for HealthyTNBabies, You must satisfy all eligibility requirements of HealthyTNBabies and:

- a. be a US citizen, or qualified alien;
- b. live in Tennessee;
- c. not have health insurance in the past 3 months unless it did not provide maternity coverage;
- d. not be covered under any other health plan unless it does not provide maternity coverage;
- e. meet the household income requirements; and
- f. be screened for TennCare eligibility or access to other state-sponsored Coverage; or
- g. be enrolled in CoverTN.

If you are Covered under CoverKids through the buy-in program and become pregnant, You may opt to buy-in the HealthyTNBabies plan.

ENROLLMENT

Eligible pregnant women may be enrolled for Coverage as set forth in this section. We will receive enrollment information from the State or the State's Eligibility Contractor.

EFFECTIVE DATE OF COVERAGE

The effective date of Coverage will be determined by the State or the State's Eligibility Contractor.

PREMIUM PAYMENT

"Premium" in this Member Handbook means Your payment to participate in the state funded Plan. Some Members are required to pay a one-time lump sum maternity Premium in order to receive maternity benefits. This one-time lump sum Premium will be billed upon confirmation of pregnancy. The Premium is required to be paid in full before maternity benefits will be activated.

TERMINATION AND CONTINUATION OF COVERAGE

A. Termination

You may terminate Your Coverage at any time with or without cause by contacting the Eligibility Contractor at 1-866-620-8864.

The State may terminate Your Coverage:

1. On the last day of the month following 60 days post-partum; or if
2. You move out-of-state (unless You can maintain Coverage under CoverTN); or if
3. You are found to be ineligible; or if
4. You enroll in other health insurance.

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 Member Handbook. The fact that You have appealed shall not postpone or prevent Us 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 Us for consideration, in accordance with the "Claims Procedure" section of this Member Handbook.

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, We or the Provider who rendered those services, may recover any charges for such services from You, plus any costs of recovering such charges, including attorney's fees.

D. Modification or Termination by State.

The State reserves the right to modify or terminate this Plan at any time, without notice.

All Members' Coverage through the Plan will change or terminate at 12:00 midnight on the date of such modification or termination. The State's failure to notify You of the modification or termination of Your Coverage does not continue or extend Your Coverage beyond the date that the Plan is modified or terminated. You have no vested right to Coverage under this Plan following the date of the termination.

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 Us. 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. You should not be billed or charged for Covered Services rendered by Network Providers, except for required Member Copayments. The Network Provider will submit the claim directly to Us.
2. You may 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 Our 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 practices, 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 a Monthly Claims Statement (MCS). 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 MCS will show the status of Your benefits. We will send the MCS monthly 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 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
1 Cameron Hill Circle, Suite 0002
Chattanooga, Tennessee 37402-0002

PRIOR AUTHORIZATION, CARE MANAGEMENT, MEDICAL POLICY AND PATIENT SAFETY

We provide services to help manage Your care including, performing Prior Authorization of certain services to ensure they are Medically Necessary, Concurrent Review of hospitalization, discharge planning, lifestyle and health counseling, low-risk case management, catastrophic medical and transplant case management and the development and publishing of medical policy.

We do not make medical treatment decisions under any circumstances. You may always elect to receive services that do not comply with Our Care Management requirements or medical policy, but doing so may affect the Coverage of such services.

A. Prior Authorization

We must Authorize some Covered Services in advance in order for those Covered Services to be paid at the Maximum Allowable Charge without Penalty. Obtaining Prior Authorization is not a guarantee of Coverage. All provisions of the Member Handbook must be satisfied before Coverage for services will be provided.

Refer to Attachment C: Schedule of Benefits for details on benefit penalties for failure to obtain Prior Authorization.

Network Providers in Tennessee will request Prior Authorization for You.

For the most current list of services that require Prior Authorization, call customer service or visit our Web site at www.bcbst.com.

We may authorize some services for a limited time. We must review any request for additional days or services.

Network Providers in Tennessee are required to comply with all of Our medical management programs. You are held harmless (not responsible for Penalties) if a Network Provider in Tennessee fails to comply with Care Management program and Prior Authorization requirements, unless You agreed that the Provider should not comply with such requirements.

Contact Our customer service department for a list of Covered Services that require Prior Authorization.

B. Care Management - CaringStart®

Your health plan wants to help You have a healthy pregnancy! Our CaringStart Maternity Program can help. CaringStart is available to You as a Member of HealthyTNBabies. The program is voluntary and does not take the place of Your doctor's care. We work with Your doctor to make sure You get the quality care and services that You need. CaringStart will give You important pregnancy-related health care information and health screenings that can identify health risks early in Your pregnancy. It provides You with the information that You need to care for Yourself during pregnancy, such as practicing good nutrition, getting plenty of rest, exercising sensibly, and avoiding things that could harm You or Your baby.

You will have easy phone access to registered nurses with obstetrics experience who serve as Your clinical health coach. They will answer Your questions and help You decide when You should see Your doctor. The clinical health coach will follow Your progress throughout Your pregnancy and provide ongoing support and advice.

So take steps now to help give Your baby the very best start in life! The CaringStart Team is available to answer Your questions and get You started in the program.

You can contact them Monday through Friday, from 8 a.m. to 6 p.m. (ET). Just call the toll-free number **1-888-416-3025**.

C. 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.

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 services.

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 without formal notice. You may check Our medical policies at www.bcbst.com. Enter “medical policy” in the Search field. Our Medical Policies are made a part of this Member Handbook by reference.

Medical policies sometimes define certain terms. If the definition of a term defined in a medical policy differs from a definition in this Member Handbook, the medical policy definition controls.

D. Patient Safety

If You have a concern with the safety or quality of care You received from a Network Provider, please call Us at the number on the membership ID card. Your concern will be noted and investigated by Our Clinical Risk Management department.

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 Us to provide the same or similar benefits for any other Member.

SUBROGATION AND RIGHT OF REIMBURSEMENT

Subrogation Rights

The Plan assumes and is subrogated to Your legal rights to recover any payments the Plan makes for Covered Services, when Your illness or injury resulted from the action or fault of a third party. The Plan's subrogation rights include the right to recover the reasonable value of prepaid services rendered by Network Providers. We will help enforce that right on behalf of the State and the Plan.

The Plan has the right to recover any and all amounts equal to the Plan's payments from:

- the insurance of the injured party;
- the person, company (or combination thereof) that caused the illness or injury, or their insurance company; or
- any other source, including uninsured motorist coverage, medical payment coverage, or similar medical reimbursement policies.

This right of recovery under this provision will apply whether recovery was obtained by suit, settlement, mediation, arbitration, or otherwise. The Plan's recovery will not be reduced by Your negligence, nor by attorney fees and costs You incur.

Priority Right of Reimbursement

Separate and apart from the Plan's right of subrogation, the Plan shall have first lien and right to reimbursement. The Plan's first lien supersedes any right that You may have to be "made whole". In other words, the Plan is entitled to the right of first reimbursement out of any recovery You might procure regardless of whether You have received compensation for any of Your damages or expenses, including Your attorneys' fees or costs. This priority right of reimbursement supersedes Your right to be made whole from any recovery, whether full or partial. In addition, You agree to do nothing to prejudice or oppose the Plan's right to subrogation and reimbursement and You acknowledge that the Plan precludes operation of the "made-whole", "attorney-fund", and "common-fund" doctrines. You agree to reimburse the Plan 100% first for any and all benefits provided through the Plan, and for any costs of recovering such amounts from those third parties from any and all amounts recovered through:

- Any settlement, mediation, arbitration, judgment, suit, or otherwise, or settlement from Your own insurance and/or from the third party (or their insurance);
- Any auto or recreational vehicle insurance coverage or benefits including, but not limited to, uninsured motorist coverage;
- Business and homeowner medical liability insurance coverage or payments.

The Plan may notify those parties of its lien and right to reimbursement without notice to or consent from You.

This priority right of reimbursement applies regardless of whether such payments are designated as payment for (but not limited to) pain and suffering, medical

benefits, and/or other specified damages. It also applies regardless of whether You are a minor.

This priority right of reimbursement will not be reduced by attorney fees and costs You incur.

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.

Notice and Cooperation

Members are required to notify the administrator promptly if they are involved in an incident that gives rise to such subrogation rights and/or priority right of reimbursement, to enable the administrator to protect the Plan's rights under this section. Members are also required to cooperate with the administrator and to execute any documents that the administrator, acting on behalf of the Employer, deems necessary to protect the Plan's rights under this section.

The Member shall not do anything to hinder, delay, impede or jeopardize the Plan's subrogation rights and/or priority right of reimbursement. Failure to cooperate or to comply with this provision shall entitle the Plan to withhold any and all benefits due the Member under the Plan. This is in addition to any and all other rights that the Plan has pursuant to the provisions of the Plan's subrogation rights and/or priority right of reimbursement.

If the Plan has to file suit, or otherwise litigate to enforce its subrogation rights and/or priority right of reimbursement, You are responsible for paying any and all costs, including attorneys' fees, the Plan incurs in addition to the amounts recovered through the subrogation rights and/or priority right of reimbursement.

Legal Action and Costs

If You settle any claim or action against any third party, You shall be deemed to have been made whole by the settlement and the Plan shall be entitled to collect the present value of its rights as the first priority claim from the settlement fund immediately. You shall hold any such proceeds of settlement or judgment in trust for the benefit of the Plan. The Plan shall also be entitled to recover reasonable attorneys' fees incurred in collecting proceeds held by You in such circumstances.

Additionally, the Plan has the right to sue on Your behalf, against any person or entity considered responsible for any condition resulting in medical expenses, to recover benefits paid or to be paid by the Plan.

Settlement or Other Compromise

You must notify Us prior to settlement, resolution, court approval, or anything that may hinder, delay, impede or jeopardize the Plan's rights so that the Plan may be present and protect its subrogation rights and/or priority right of reimbursement.

The Plan's subrogation rights and priority right of reimbursement attach to any funds held, and do not create personal liability against You.

The right of subrogation and the right of reimbursement are based on the Plan language in effect at the time of judgment, payment or settlement.

The Plan, or Us as its representative, may enforce the subrogation and priority right of reimbursement.

GRIEVANCE PROCEDURE

I. INTRODUCTION

We administer the Grievance Procedure for the Plan. 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 Member Handbook or other documents that are related to Your Coverage (e.g. an explanation of benefits or monthly claims statement); or (3) to initiate a Grievance concerning a Dispute.

1. The Procedure can only resolve Disputes that are subject to the Plan's control.
2. 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 Us, however, to complain about any matter related to the quality or availability of services, or any other aspect of Your relationship with Providers.
3. 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. In addition, an Adverse Benefit Determination includes any rescission of Coverage or a denial of Coverage in an initial eligibility determination.
 - 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 Us 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 Us 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. Our 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 We have rendered a final Adverse Benefit Determination in a matter being appealed through the Provider dispute resolution procedure.
4. You may request a form from Us to authorize another person to act on Your behalf concerning a Dispute.
5. We and You may agree to skip one or more of the steps of this Procedure if it will not help to resolve Our Dispute.
6. Any Dispute will be resolved in accordance with applicable Tennessee or Federal laws and regulations, the Contract and this Member Handbook.

II. DESCRIPTION OF THE REVIEW PROCEDURES – MEDICAL RELATED APPEALS

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 Us 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 30 days from the date We issue notice of an Adverse Benefit Determination; or if no notice was sent, within 6 months from the date of the Adverse Benefit Determination. If You do not initiate a Grievance within this time frame, 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 Procedure and is mandatory.

1. Grievance Hearing

After We have 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 Your Coverage.

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 30 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. We will send You a copy of such documentation or information, without charge, upon written request.

C. State Informal Review

The State of Tennessee, Division of Health Care Finance and Administration has an appeal process that is available to You AFTER You have exhausted the grievance process with the claims administrator. Appeals must be requested in writing within 8 days of the claim determination or decision. To file an appeal at the state level, the member should send a letter and supporting documentation (e.g., explanation of benefit statements, decision letters, statements from healthcare providers, and medical records) to:

Appeals Coordinator, Division of Health Care Finance and Administration
26th Floor, Wm. R. Snodgrass Tennessee Tower
312 Rosa L. Parks Avenue
Nashville, TN 37243-1102

If Your request is not received by the Division of Health Care Finance and Administration within 8 days, You may give up the right to further review. It is a good idea to maintain a copy of all correspondence You send. Specific questions regarding the appeal process may be directed to the appeals coordinator at 615-741-4517 or 1-866-576-0029.

The appeals coordinator in the Division of Health Care Finance and Administration may also request review by the state's independent medical consultant. A written decision of the appeal coordinator should be issued within 20 days of receipt of the request for further review.

D. State Review Committee

If the informal review does not grant the relief requested, the request will be scheduled for review by the CoverKids/HealthyTNBabies Review Committee. The Committee will be composed of five members, including Division of Insurance Administration staff and at least one licensed medical professional, selected by the Commissioner or his designee. The members of the Committee will not have been directly involved in the matter under review. You will be given the opportunity to review the file, be represented by a person of Your choice, and provide supplemental information. The Committee may allow You to appear in person if it finds that scheduling the appearance will not cause delay in the review process. The Review Committee is not required to provide an in-person hearing or a contested case under the Uniform Administrative Procedures Act. You will receive written notification of the final decision stating the reasons for the decision. The decision of the CoverKids/HealthyTN Babies Review Committee is the final administrative recourse available to the Member.

E. Time for Reviews

Review of all non-expedited health services appeals will be completed within 90 days of receipt of the initial request for review by the Plan. Reviews by both the Appeals Coordinator and the Committee may be expedited (completed within 72 hours at each the Plan and State levels) for situations in which a benefit determination or a preauthorization denial has been made prior to services being received and the attending medical professional determines in writing (including legible handwriting) that the medical situation to be life threatening or would seriously jeopardize the Member's health or ability to attain, maintain or regain maximum functioning.

III. DESCRIPTION OF THE REVIEW PROCEDURES - ELIGIBILITY RELATED APPEALS

A. Informal Review

You may request review of an eligibility issue by writing or calling the Eligibility Contractor (EC). The EC's address and toll-free number are provided in the front of this Handbook. A request for review must be received within 30 days of issuance of written notice of the action for which review is requested or, if notice is not provided, 30 days from the time the applicant becomes aware of the action. If the EC's review is not favorable, a formal written request can be submitted to Division of Health Care Finance and Administration for review by the state-level CoverKids/HealthyTNBabies Eligibility Appeals Committee.

B. Formal Review

You may request further review by sending a letter and supporting documentation to:

Appeals Coordinator, Division of Health Care Finance and Administration
26th Floor, Wm. R. Snodgrass Tennessee Tower
312 Rosa L Parks Avenue
Nashville, TN 37243-1102

Requests must be received by Division of Health Care Finance and Administration within 30 days of the issuance of the informal review decision. If Your request is not received within 30 days, You may give up the right to further review. Receipts of requests for review will be acknowledged in writing within 10 days, including notification that a decision should be issued within one calendar month of receipt of the acknowledgment letter.

The request will be scheduled for review by the CoverKids/HealthyTNBabies Review Committee. The Committee will be composed of five members, including Division of Health Care Finance and Administration staff and at least one licensed medical professional, selected by the Commissioner or his designee. The members of the Committee shall not have been directly involved in the matter under review. You will receive written notification of the Committee's decision, stating the reasons for the decision. The decision of the CoverKids/HealthyTNBabies Review Committee is the final administrative recourse available to the You.

GENERAL PROVISIONS

A. Applicable Law

The laws of Tennessee govern this Plan.

B. Notices

All notices required by this Plan must be in writing. Notices should be addressed to:

BlueCross BlueShield of Tennessee, Inc.
1 Cameron Hill Circle
Chattanooga, TN 37402-2555

We will send notices to You at the most recent address in Our files.

C. Legal Action

You cannot bring legal action under this Coverage until 60 days after proof of loss has been furnished. You cannot bring legal action after 3 years after the time proof of loss is required.

D. Right to Request Information

We have the right to request any additional necessary information or records with respect to the administration of this Plan.

E. Coordination of Benefits

This Plan is not subject to Tennessee's Coordination of Benefits Regulation and does not Coordinate Benefits. When We discover You have other Coverage, this Plan will terminate. Other Coverage includes other group or individual coverage, Medicare and Medicaid. Until termination, if You are enrolled in this Plan at the same time You are enrolled in:

1. Medicare, or another group or individual coverage, this Plan will pay secondary; or
2. Medicaid, this Plan will pay primary.

F. Administrative Errors

If We make an error in administering the benefits under this Plan, We may provide additional benefits or recover any overpayments from any person, insurance company, or plan. Any recovery must begin by the end of the calendar year following the year in which the claim was paid. This time limit does not apply if the Member did not provide complete information or if material misstatements or fraud have occurred. This time limit does not apply to recoveries from Network Providers.

No such error may be used to demand more benefits than those otherwise due under this Plan.

DEFINITIONS

Defined terms are capitalized. When defined words are used in this Member Handbook, 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 Member Handbook.

1. **Acute** - An illness or injury which is both severe and of short duration.
2. **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.
3. **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.
4. **Brand Name Drug** - a Prescription Drug identified by its registered trademark or product name given by its manufacturer, labeler or distributor.
5. **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.
6. **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.
7. **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
8. **Compound Drug** - An outpatient Prescription Drug, which is not commercially prepared by a licensed pharmaceutical manufacturer in a dosage form approved by the U.S. Food and Drug Administration (FDA) and which contains at least one ingredient classified as a Legend Prescription Drug.
9. **Concurrent Review Process** – The process of evaluating care during the period when Covered Services are being rendered.
10. **Copayment** – 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.
11. **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.

12. **Covered Services, Coverage or Covered** - Those Medically Necessary and Appropriate services and supplies that are set forth in Attachment A of this Member Handbook. Covered Services are subject to all the terms, conditions, exclusions and limitations of the Contract and this Member Handbook.
13. **Custodial Care** - Any services or supplies provided to assist an individual in the activities of daily living as determined by Us including but not limited to eating, bathing, dressing or other self care activities.
14. **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.
15. **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 Us.
16. **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.
17. **Emergency Care Services** - Those services and supplies that are Medically Necessary and Appropriate in the treatment of an Emergency.
18. **Enrollment Form** – A form or application, which must be completed in full for the eligible pregnant woman before she will be considered for Coverage under the Plan.
19. **Experimental and/or Investigational Drugs** – Drugs or medicines, which are labeled: “Caution – limited by federal law to Investigational use.”
20. **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.
21. **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.
22. **Hospital Services** - Covered Services which are Medically Appropriate to be provided by an Acute care hospital.
23. **Inmate** – an individual confined in a local, state or federal prison, jail, youth development center, or other penal or correctional facility, including a furlough from such a facility.
24. **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. in the predominant opinion of experts, as expressed in the published authoritative literature, that usage should be substantially confined to research settings, or
- g. 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
- h. 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 Us 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.

25. **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.”

26. **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.
27. **Maximum Allowable Charge** – The amount that We, at Our sole discretion, have determined to be the maximum amount payable for a Covered Service. That determination will be based upon Our contract with a Network Provider for Covered Services rendered by that Provider.
28. **Medical Director** - The physician designated by Us, or that physician's designee, who is responsible for the administration of Our medical management programs, including its authorization program.
29. **Medically Appropriate** – Services, which have been determined by the Medical Director 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.
30. **Medically Necessary or Medical Necessity** – Services which have been determined by Us to be of proven value for use in the general and/or specialized population, as appropriate. 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.
31. **Medicare** - Title XVIII of the Social Security Act, as amended, and coverage under this program.
 32. **Member, You, Your** - An Eligible pregnant woman enrolled under the HealthyTNBabies program.
 33. **Member Payment** – The Copayment amounts for Covered Services that You are responsible for as set forth in Attachment C: Schedule of Benefits. We may require proof that You have made any required Member Payment.
 34. **Network Benefit** – Our payment level that applies to Covered Services received from a Network Provider. See Attachment C: Schedule of Benefits.
 35. **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 Member Handbook, either in person or through home delivery.
 36. **Network Provider** - A Provider who has contracted with Us 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.
 37. **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 Us. 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.
 38. **Non-Routine Diagnostic Services** – Services listed under non-routine diagnostic services in Attachment A: Covered Services.
 39. **Out-of-Network Pharmacy** - A Pharmacy which has not entered into a service agreement with BCBST or its agent to provide benefits under this Member Handbook at specified rates to Members Covered under this Member Handbook.
 40. **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.
 41. **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.
 42. **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.
 43. **Pharmacy and Therapeutics Committee or P&T Committee** - A panel of Our 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 and 2) Quantity Limitation list. The P&T Committee may also set dispensing limits on medications.

44. **Practitioner** – A person licensed by the appropriate State to provide medical services.
45. **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 [or dispensing physician] for a drug, or drug product to be dispensed.
46. **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.
47. **Prior Authorization, Authorized** – A review conducted by Us, prior to the delivery of certain services, to determine if such services will be considered Covered Services.
48. **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.
49. **Quantity Limitation** – Quantity limitations applied to certain Prescription Drug products as determined by the Pharmacy and Therapeutics Committee.
50. **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 Our Specialty Pharmacy Products list. Specialty Pharmacy Products are categorized as provider-administered or self-administered.

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 You; inform You of Our legal obligations; and advise You of additional rights concerning Your medical information. We must follow the privacy practices contained in this notice from its effective date of April 14, 2003, until this notice is changed or replaced.

We reserve the right to change privacy practices and the terms of this notice at any time, as permitted by Our 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 Our 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.

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 Our Members may be shared with each other as needed for treatment, payment or health care operations.

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 benefit plan.

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

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.

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 Our cost of providing Your medical information in that format. If You prefer, We 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. We 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 Us 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 Our use or disclosure of Your medical information. We are not required to agree to such requests. **We 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 We

communicate 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.** We 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 We amend Your medical information. **Your request must explain why the information should be amended.** We may deny Your request if the medical information You seek to amend was not created by Us or for other reasons permitted by Our legal obligations. If Your request is denied, We 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 We accept Your request, We 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.

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 We have violated Your privacy rights; or
2. 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
3. You wish to request We 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. We 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**

UNFAIR TREATMENT

You have a right to fair treatment. If You think You have been treated unfairly, this page tells You whom to contact.

We do not allow unfair treatment in CoverKids.

State and Federal laws protect You from unfair treatment. No one can treat You in a different way because of Your:

- Race
- Birthplace
- Sex
- Beliefs
- Disability
- Color
- Language
- Religious
- Age

In CoverKids, unfair treatment could mean many things. It could mean someone treated You differently because of one of the things listed above. For example:

- Maybe they did not let You take part in the same things as other people.
- Maybe You did not get the help You needed to get health care.
- Maybe You did not get the health care that You needed.

Do You think You have been treated unfairly? You may contact any of the places listed below for help. You also have the right to file a complaint. By law, no one can get back at You for filing a complaint.

This is who You can contact if You are treated unfairly under CoverKids.

Is Your problem with Your:

- **Physical health care? Then call BlueCross BlueShield of Tennessee (BCBST) at 1.888.325.8386**
- **Mental health care? Then call BCBST at 1.888.325.8386**
- **Dental care? Then call DentaQuest at 1.888.291.3766**

Call their Member Services line. The number is listed in Your Member Handbook. Ask to speak with the Non-discrimination Compliance Coordinator.

CoverKids

You can call the Office of Non-Discrimination at:
1-855-286-9085.

You can write to:

CoverKids Program
ATTN: Director of Non-Discrimination Compliance
310 Great Circle Road, 4th Floor
Nashville, TN 37243

Fax: (615) 253-2917
TTY: Toll-Free (877) 779-3103

**U.S. Department of Health & Human Services
Office of Civil Rights**

You can call (800) 368-1019 for free.

You can write to:

Director, Office of Civil Rights
U.S. Department of Human Services
200 Independence Ave., SW – Room 506 F
Washington, DC 20201

TTY: Toll-Free (800) 537-7697

**U.S. Department of Health & Human Services
Region IV Office of Civil Rights**

You can call: (404) 562-7859

You can write to:

U.S. DHHS/Region IV Office of Civil Rights
61 Forsyth Street, SW – 3rd Floor, Suite 3B70
Atlanta, GA 30303

Fax: (404) 562-7861

THRC – Tennessee Title VI Compliance Program

You can call: (615) 532-4882

You can write to:

Director
Andrew Jackson Tower – 1st Floor
710 James Robertson Parkway
Nashville, TN 37243-0635

Fax: (615) 253-1886

Unfair Treatment Complaint



Federal law says that unfair treatment is not allowed. No one can be treated in a different way because of race, color, birthplace, language, sex, age, beliefs or disability. If You feel that You have been treated unfairly for any of these reasons, You have the right to complain. We do not allow unfair treatment in CoverKids. We need the following facts so we can look into Your complaint. If You need help to fill out this page, let Us know.

1. **Are You filing this complaint for Yourself?** Yes No

If yes, go to question number 2.

If no, tell us Your name: _____

Give Us a phone number where We can reach You: (_____) _____

2. **What is the name of the person You feel was treated unfairly?**

Name of Person You Feel Was Treated Unfairly _____ Last First Middle Initial			Date of Birth _____/_____/_____ Month Day Year
Full Mailing Address: _____ Street Number and Name, Rural Route, Apartment Number, Lot Number, PO Box, etc.			Social Security Number: _____
City: _____	State: _____	Zip: _____	Daytime Phone (_____) Evening Phone (_____)

3. **Who do You think treated this person unfairly?**

Name _____

Address _____

City, State, ZIP Code _____

Phone Number (_____) _____ - or - (_____) _____

4. **Give us facts about the unfair treatment.**

Check the box or boxes that You think were the reason for the unfair treatment.

- Race Color Birthplace Language Spoken Sex
 Religion Beliefs Age Disability

What date did the unfair treatment take place? _____

Do You think it happened other times? Yes No

If yes, how many other times? _____

Have You complained about this problem before and tried to have it stopped? Yes No

If yes, who have You talked to about it? Name: _____

When did You talk to them about it? _____

Have You filed this complaint with another federal, state or local agency? Yes No
 Have You filed this complaint with any federal or state court? Yes No
 If yes, check all that apply. Federal agency Federal court State agency
 State court Local agency

If yes, tell us the name of the contact person at the agency/court where You filed the complaint.

Name _____

Agency/Court Name _____

Address _____

City, State, ZIP Code _____

Phone Number (_____) _____

5. In Your own words, tell us what happened. You can attach more pages if You need them.

Please sign below. Attach any other information that You think will be helpful.

Sign here _____ Date _____

If You filled out this page for someone else, sign here _____

[Note: if You helped someone file this complaint, You don't have to sign.]

Print Your name _____ Date _____

Mail these pages to: CoverKids Program
 Attn: Director of Non-discrimination Compliance
 310 Great Circle Road
 Nashville, TN 37243

If You have questions, please call 1-855-286-9085 (toll-free) for help. TTY: (toll-free) 1-877-779-3103.

To get help in one of the following languages, call 1-866-268-3786.

- Arabic
- Bosnian
- Kurdish-Badinani
- Kurdish-Sorani
- Somali
- Spanish
- Vietnamese

CoverKids does not allow unfair treatment based on race, color, language spoken, sex, sexual orientation, religion, beliefs, handicap/disability or age.

**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 Member Handbook. 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 Our Medical Policies and medical management procedures. (See Medical Policy and 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 Us for Covered Services. Maximum Allowable Charge is what We have 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 the amount above the Maximum Allowable Charge.

Out-of-Network Providers do not have a contract with Us. This means they will be able to charge You more than the amount set by Us in Our 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 Our 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 Member Handbook must be satisfied before Coverage for services will be rendered. Our Medical Policies can help Your Provider determine if a proposed service will be Covered.

Referrals are not required for specialty care.

**Covered Services are limited to those in connection with Your pregnancy including complications of pregnancy as defined; and Prescription Drugs.
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. Midwife services are eligible when performed in a facility.

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.
2. In a true Emergency, You have benefits for Out-of-Network Providers (Facility and Practitioners).

II. ELIGIBLE SERVICES:

Medically Necessary and Appropriate services in connection with pre and post natal maternity care, including complications of pregnancy, after the initial diagnosis of pregnancy. Services and supplies for conditions other than Your pregnancy, including complications are not Covered.

A. Practitioner Office Services

Medically Necessary and Appropriate services for pre and post natal care, including complications of pregnancy, in a Practitioner's office.

1. Covered
 - a. Office visits.
 - b. Diagnostic laboratory and x-ray examinations.
2. Exclusions
 - a. Services and supplies not related to the pregnancy (pre and post natal care).

B. Inpatient Hospital Services

Medically Necessary and Appropriate services and supplies for pre and post natal care, including complications of pregnancy, performed 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. Prior Authorization is required for any non-delivery hospital admission and observation stays.

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.
2. Exclusions

- a. Services and supplies not related to the pregnancy (pre and post natal care).
- b. Private room when not authorized by the Plan and room and board charges are in excess of semi-private room.

C. Hospital Emergency Care Services

Medically Necessary and Appropriate health care services and supplies furnished in a Hospital which are related to the pregnancy (pre and post natal care) or complications of pregnancy and required to determine, evaluate and/or treat an Emergency until such condition is stabilized, as directed or ordered by the Practitioner or Hospital protocol.

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 and supplies not related to the pregnancy (pre and post natal care).

D. 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 or air transportation, services, supplies in connection with the pregnancy or complications of pregnancy.
2. Exclusions
 - a. Transportation for Your convenience.
 - b. Transportation that is not in connection with Your pregnancy..
 - c. Services when You are not transported to a facility.

E. Outpatient Facility Services

Medically Necessary and Appropriate diagnostics, therapies and surgery performed in connection with the pregnancy or complications of pregnancy and 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.
2. Exclusions

- a. Services and supplies not related to the pregnancy (pre and post natal care).

F. Diagnostic Services

Medically Necessary and Appropriate diagnostic radiology services and laboratory tests in connection with pregnancy or complications of pregnancy.

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 or not in connection with pregnancy or complications of pregnancy.
- b. Diagnostic Services not ordered by a Practitioner.

G. Prescription Drug Program

Benefits are provided for formulary prescription drugs and insulin prescribed when You are not confined in a hospital or other facility. Check Your CoverKids/HealthyTNBabies Preferred Drug List and Pharmacy Program booklet for the list of Prescription Drugs Covered by Your Pharmacy plan.

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

Benefits are limited to a 30 day supply when purchased at a retail pharmacy. Some medications can be purchased up to a 90 day supply through home delivery or certain retail pharmacies. Some products may be subject to additional Quantity Limitations as adopted by Us.

The prescribing Provider shall allow for substitution with a Generic Drug for a Preferred or Non-preferred Brand Name Drug (when available) under all circumstances, unless the prescribing Provider determines medical necessity of a Brand Name Drug (Preferred or Non-preferred) due to:

- a. You previously experienced an adverse reaction to the Generic Drug;
- b. the Generic Drug has been demonstrated to be ineffective for You; or
- c. any other clinically based need determined by the prescribing Provider.

If You choose a Brand Name Drug (Preferred or Non-preferred) when a Generic Drug equivalent is available, You will be financially responsible for the amount by which the cost of the Brand Name Drug exceeds the Generic Drug cost plus the required Generic Drug copayment.

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

BENEFITS FOR SELF-ADMINISTERED SPECIALTY PHARMACY PRODUCTS

There is a distinct network for Specialty Pharmacy Products: the specialty pharmacy network. The Member receives the highest level of benefits when a specialty

pharmacy network provider is used for self-administered Specialty Pharmacy Products.

Specialty Pharmacy Products are limited to a 30-day supply per Prescription. Some Specialty Pharmacy Products require Prior Authorization. Please refer to the Specialty Pharmacy Drug Listing for a list of Specialty Pharmacy products requiring Prior Authorization.

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.
- f. Compound Drugs are only Covered when filled at a Network Pharmacy. The Network Pharmacy must submit the claim through the pharmacy benefit manager. The claim must contain a valid national drug code (NDC) number for at least one ingredient in the Compound Drug.
- g. Smoking deterrents, such as patches, provided for assistance in smoking cessation. The following limitations apply to this benefit:
 - (a) Prescription must be written by a licensed physician;

- (b) Prescriptions are for a 90-day period only; and
- (c) Benefit is allowable once per plan year, with a maximum lifetime benefit of two 90-day periods.

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 Member Handbook;
- 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 Member Handbook;
- c. any quantity of Prescription Drugs which exceed that specified by Our 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. DESI (Drug Efficiency Safety Implementation) and LTE (Less Than Effective) Drugs;
- o. Experimental and/or Investigational Drugs;
- p. Prescription Drugs obtained from an Out-of-Network Pharmacy;
- q. Provider-administered Specialty Pharmacy Products, as indicated on Our Specialty Pharmacy Products list, except as otherwise Covered in this Member Handbook.
- r. Prescription Drugs or refills dispensed:

- (1) in quantities in excess of amounts specified in the BENEFIT PAYMENT section; or
- (2) which exceed any applicable maximum benefit amounts stated in this Member Handbook.

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

H. Newborn Care

Medically Necessary and Appropriate nursery and pediatric care of a healthy term newborn.

1. Covered

- a. Nursery and routine pediatric care while mother confined to hospital.
- b. Circumcision.
- c. Physician charges for routine visits to newborn while confined and not requiring treatment.

2. Exclusions

- a. Services and supplies not in connection with routine nursery care.

ATTACHMENT B: EXCLUSIONS FROM COVERAGE

HealthyTNBabies 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. Self treatment or training.
6. Staff consultations required by hospital or other facility rules.
7. Services which are free.
8. 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; (15) diapers; or (16) self-help devices which are not primarily medical in nature, even if ordered by a Practitioner.
9. Services or supplies received before Your effective date for Coverage with this Plan.
10. Services or supplies related to a Hospital Confinement, received before Your effective date for Coverage with this Plan.
11. 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.
12. Services or supplies received in a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union or similar group.
13. 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.
14. Services for providing requested medical information or completing forms. We will not charge You or Your legal representative for statutorily required copying charges.
15. Court ordered examinations and treatment, unless Medically Necessary.
16. Room, board and general nursing care rendered on the date of discharge, unless admission and discharge occur on the same day.
17. Charges in excess of the Maximum Allowable Charge for Covered Services or any charges which exceed the individual benefit limits.
18. Any service stated in the Attachment A as a non-Covered Service or limitation.
19. Charges for services performed by You or Your spouse, or Your or Your spouse's parent, sister, brother or child.

20. Any charges for handling fees.
21. Safety items, or items to affect performance primarily in sports-related activities.
22. 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.
23. Services or supplies for Maintenance Care.
24. Private duty nursing that would normally be provided by nursing staff.
25. Pharmacogenetic testing.
26. Services or supplies to treat sexual dysfunction, regardless of cause, including but not limited to erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido.
27. Services or supplies for methadone maintenance therapy and buprenorphine maintenance therapy.
28. Provider-administered Specialty Pharmacy Products, except those specifically included in Attachment A, Covered Services.
29. Services for planned maternity delivery in a home setting or location other than a licensed Hospital or birthing center
30. Services, supplies and charges not related to the pregnancy or any complication of the pregnancy.
31. Services or supplies for Inmates confined in a local, state or federal prison or jail, or other penal correctional facility, including a furlough from such facility.
32. Services or supplies for the treatment of work related illness or injury, regardless of the presence or absence of workers' compensation coverage.

We do not allow unfair treatment in CoverKids/HealthyTNBabies.

No one is treated in a different way because of race, beliefs, language, birthplace, disability, religion, sex, color, or age. Read more about Your right to fair treatment in "**UNFAIR TREATMENT**" section of this Member Handbook.



BlueCross BlueShield of Tennessee
1 Cameron Hill Circle | Chattanooga, TN 37402
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