The following information is intended to summarize the reimbursement methodologies for BlueAdvantage Private fee-for-Service (PFFS) products:

BlueAdvantage PFFS reimburses eligible services to deemed Providers based on estimated Medicare payments (e.g., fee schedules, Prospective Payment Systems (PPS), cost-based methodologies). Payment methodologies are reviewed by the Centers for Medicare and Medicaid Services (CMS) for accuracy. Payment rates will not be less than under Original Medicare (Medicare fee-for-service) in accordance with 42 CFR 422.114.

General Provisions

Eligible services not priced by Centers for Medicare and Medicaid Services (CMS) will be based on a reasonable allowable as determined by BlueCross BlueShield of Tennessee.

Presence of a maximum allowable is not a guarantee the procedure, service or item will be eligible for reimbursement.

Final reimbursement determinations are based on several factors, including but not limited to, Member eligibility on the date of service, Medical Appropriateness, code edits, applicable Member co-payments, coinsurance, deductibles, benefits plan exclusions/limitations, coverage determinations and medical policy.

The maximum allowable subject to final reimbursement determinations represents payment in full to Provider from BlueCross BlueShield of Tennessee.

Payment in full means there will be no additional payments via periodic interim payment or cost report settlement processes.

Costs (e.g., bad debt, organ acquisition, nursing education programs, and allied health education programs, capital for new hospitals) wherein Provider's allocated expenses are otherwise paid via periodic interim payment or cost settlement processes under Original Medicare by the fiscal intermediary are not included in the maximum allowable for BlueAdvantage PFFS products. These expenses should not be submitted to the Medicare fiscal intermediary unless otherwise directed by CMS or the Medicare fiscal intermediary.

BlueCross BlueShield of Tennessee may request interim rate letters from Providers in order to determine applicable cost-based reimbursement.

BlueCross BlueShield of Tennessee reserves the right to request other documents submitted to or issued by the Medicare fiscal intermediary or carrier that are necessary to determine the appropriate maximum allowable under aforementioned Medicare based reimbursement methodology.

Details regarding Medicare reimbursement methodologies can be located on the CMS Web site located at http://cms.hhs.gov. Links to the CMS Web site for specific Provider types are included below to facilitate navigation. In the event CMS changes one or more of the links listed below, refer to main CMS Web site located at http://cms.hhs.gov.

If there is a conflict between the information provided below and information published by CMS, the information published by CMS will prevail.

Providers have a right to appeal reimbursement under BlueAdvantage PFFS. If a Provider has information that Original Medicare would pay more for a service,

documentation (e.g. copy of a remittance advise or other official notice of payment for the same service from the Medicare Fiscal Intermediary or Carrier as proof of Medicare payment) may be submitted to BlueCross BlueShield of Tennessee, Attn: BlueAdvantage, P. O. Box 180205, Chattanooga, TN 37402 for review, verification, and payment adjustment if appropriate.

Provider Type	Reimbursement Methodology Summary	CMS Link for Detailed Information
Ambulance Services	Effective 01/01/2006, reimbursement is based on the Medicare Ambulance Fee Schedule unless otherwise specified by CMS.	http://www.cms.hhs.gov/AmbulanceFeeSchedule/
Ambulatory Surgical Center (ASC)	Reimbursement is based on the Hospital Outpatient Prospective Payment System (OPPS) unless otherwise specified by CMS.	http://www.cms.hhs.gov/HospitalOutpatientPPS/
Clinical Laboratory	Reimbursement is based on the Medicare Clinical Laboratory Fee Schedule unless specified otherwise by CMS.	http://www.cms.hhs.gov/ClinicalLabFeeSched/
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	Reimbursement is based on the Medicare Durable Medical Equipment, Prosthetic, Orthotic, and Supplies (DMEPOS) Fee Schedule unless otherwise specified by CMS.	http://www.cms.hhs.gov/DMEPOSFeeSched/
End Stage Renal Disease (ESRD) Center	Reimbursement is based on a composite rate for hospital based ESRD facilities, independent ESRD facilities, and home dialysis services for beneficiaries who select Method I for home dialysis payments. Reimbursement for Method II home dialysis is based on reasonable charges limited to a monthly cap.	http://www.cms.hhs.gov/center/esrd.asp
Federally Qualified Health Centers (FQHC)	Reimbursement is based on 80 percent of the lower of the all-inclusive rate or the upper limit; plus 20 percent of the FQHC's actual charge unless otherwise specified by CMS.	http://www.cms.hhs.gov/center/fqhc.asp
Home Health	Reimbursement is based on the Prospective Payment System (PPS), under home health resource groups (HHRGs) methodology unless otherwise specified by CMS. Providers are reimbursed per 60-day episode of care via submission of a request for accelerated payment (RAP) and the claim. Reimbursement includes adjustments for low utilization payment adjustment (LUPA), significant change in condition (SCIC), partial episode payment (PEP), therapies and outliers. Limited services are reimbursed under OPPS. DME is reimbursed based on the DMEPOS fee schedule.	http://www.cms.hhs.gov/HomeHealthPPS/

Hospice	Reimbursement for hospice services is considered a carve-out for Medicare Advantage Program and not payable under BlueAdvantage, BlueAdvantage Silver, BlueAdvantage Gold, and BlueAdvantage Platinum. These services should be billed to Original Medicare for reimbursement.	http://www.cms.hhs.gov/center/hospice.asp
Provider Type	**Reimbursement Methodology Summary**	**CMS Link for Detailed Information**
Hospitals		http://www.cms.hhs.gov/center/hospital.asp
Acute Inpatient Services	Reimbursement is based on the Inpatient Prospective Payment System (PPS), under Diagnosis Related Groups (DRGs) methodology unless specified otherwise by CMS. Reimbursement under DRG includes appropriate capital disproportionate share hospital (DSH) and capital indirect medical education (IME) payments. Payments for operating IME, graduate medical education (GME), nursing school, allied health education costs and capital exceptions are considered a carve-out for Medicare Advantage Programs and are not payable under BlueAdvantage Plan. These payments are paid through the fiscal intermediary, if applicable.	http://www.cms.hhs.gov/AcuteInpatientPPS/
Critical Access Hospitals	Critical Access Hospitals (CAHs) are exempt from the Inpatient and Outpatient Prospective Payment Systems (PPS). Reimbursement for CAHs is based on current Medicare allowable costs or cost based reimbursement and are paid cost for ambulance services if the CAH is the only ambulance supplier within 35 miles unless otherwise specified by CMS.	http://www.cms.hhs.gov/center/cah.asp
Hospital - Outpatient Services	Reimbursement is based on the Outpatient Prospective Payment System (PPS), under Ambulatory Payment Classifications (APC) methodology unless specified otherwise by CMS.	http://www.cms.hhs.gov/HospitalOutpatientPPS/
Inpatient Rehabilitation Facility	Reimbursement is based on the Inpatient Rehabilitation Facility Prospective Payment System (PPS) unless otherwise specified by CMS.	http://www.cms.hhs.gov/InpatientRehabFacPPS/

Provider Type	Reimbursement Methodology Summary	CMS Link for Detailed Information
Inpatient Psychiatric Facility (IPF)	Effective with cost reporting periods beginning on or after 01/01/2005 CMS implemented a per diem Inpatient Psychiatric Facility (IPF) Prospective Payment System with a three-year transition period to replace the cost-based payment system. For the first year of the transition, reimbursement is 75 percent cost-based and 25 percent PPS. For the second year of the transition, reimbursement is 50 percent cost-based and 50 percent PPS. For the third year of the transition, reimbursement is 75 percent cost-based and 25 percent PPS. For the fourth year of the transition and after, reimbursement is 100 percent PPS. The transition period also includes a guaranteed average payment per case no less than 70 percent of the Tax Equity and Fiscal Responsibility Act (TEFRA) payment. Refer to the CMS for additional provisions for the IPF PPS reimbursement methodology.	http://www.cms.hhs.gov/InpatientPsychFacilPPS/
Provider Type	Reimbursement Methodology Summary	CMS Link for Detailed Information
Hospitals		http://www.cms.hhs.gov/center/hospital.asp
Long-Term Care Hospital	Reimbursement is based on the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) unless otherwise specified by CMS. A 5-year transition period was implemented by CMS beginning 10/01/2002 to phase-in the PPS for LTCHs from cost-based reimbursement to 100 percent Federal prospective payment. During the 5-year transition, payment will be based on an increasing percentage of the LTCH PPS payment and a decreasing percentage of its cost-based reimbursement rate for each discharge. Effective 10/01/2006, reimbursement will be based on 100 percent Federal prospective payment unless specified otherwise by CMS.	http://www.cms.hhs.gov/LongTermCareHospitalPPS/
Skilled Nursing Facilities	Reimbursement based on the Skilled Nursing Facility (SNF) Prospective Payment System (PPS) unless otherwise specified by CMS. The PPS payment rate is adjusted for case mix and geographic variation in wages and covers all costs of furnishing covered SNF services (routine, ancillary, and capital-related costs).	http://www.cms.hhs.gov/SNFPPS/
Part B Drugs	Reimbursement is generally based on Average Sales Price (ASP) methodology unless otherwise specified by CMS.	http://www.cms.hhs.gov/CompetitiveAcquisforBios/ http://www.cms.hhs.gov/HistPartBDrugPricingFiles/ http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/

Physicians and Other Healthcare Professionals	Reimbursement is based on the Medicare Physician Fee Schedule unless otherwise specified by CMS. Services are generally reimbursed based on Resource Based Relative Value Scale (RBRVS) methodology subject to adjustment for global days, pre-op, intra-op, post-op, multiple procedures, bilateral surgery, assistant surgery, co-surgery, and team surgery per the National Physician Fee Schedule Relative Value File.	http://www.cms.hhs.gov/center/physician.asp
Provisions for other common Physician and health care professional services:		
Anesthesia	Reimbursement for personally performed, medically directed, and medically supervised services is calculated based on the following formula unless otherwise specified by CMS: Anesthesia conversion factor by locality x (sum of uniform base units + time units) x percentage based on anesthesia modifier	

Provisions for other common Physician and health care professional services:

Provider Type	Reimbursement Methodology Summary	CMS Link for Detailed Information
Assistant-at Surgery Physician	Reimbursement for assistant at surgery services provided by a Physician is 16 percent of the Medicare Physician Fee Schedule.	
Assistant-at- Surgery Physician Assistant	Reimbursement for assistant at surgery services provided by a Physician is 13.6 percent (16 percent x 85 percent) of the Medicare Physician Fee Schedule.	
Clinical Nurse Specialist	Reimbursement is based on 85 percent of the Medicare Physician Fee Schedule.	
Clinical Psychologist	Reimbursement is based on 100 percent of the Medicare Physician Fee Schedule.	http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/
Clinical Social Worker	Reimbursement is based on 75 percent of the Medicare Physician Fee Schedule.	
Co-Surgery	Reimbursement is based on 62.5 percent of the Medicare Physician Fee Schedule.	
Health Professional Shortage Area (HPSA)	10 percent additional payment in accordance with CMS guidelines	
Nurse Practitioner	Reimbursement is based on 85 percent of the Medicare Physician Fee Schedule.	
Physician Assistant	Reimbursement is based on 85 percent of the Medicare Physician Fee Schedule.	
Registered Dietitian	Reimbursement is based on 85 percent of the Medicare Physician Fee Schedule.	http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/

Rural Health	Reimbursement for independent or Provider based Rural Health Clinics (RHC) is based on 80 percent of the lower of the Provider specific rate or the per visit payment limit; plus 20 percent of the RHC's actual charges unless otherwise specified by CMS. Note: Per visit limits do not apply to RHCs owned by rural hospitals with less than 50 beds and are paid on a cost basis.	http://www.cms.hhs.gov/center/rural.asp