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## *BlueCross BlueShield of TN - PPO Plan*

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Benefit Features	Network Provider	Out-of-Network Providers
<b>Annual Deductible</b>		
Individual	\$750	\$1,500
Family	\$1,500	\$3,000
<b>Annual Out-of-Pocket Max</b>		
Individual	\$2,000	\$6,000
Family	\$4,000	\$12,000
Dependent Age Limit		To age 24
Lifetime Maximum Benefit		\$5,000,000
Pre-Existing Conditions	12 Month Waiting Period	
Benefit for Covered Services	Network Benefits	Out-of-Network Benefits
<b>Practitioner Office Services</b>		
Office Visits	\$20 Copay	60% after Deductible
Routine Diagnostic Lab, X-ray, & Injections	No Additional Copay	60% after Deductible
Non-Routine Diagnostic Services	80% after Deductible	60% after Deductible
Provider-Administered Specialty Pharmacy Products	\$50 Copay	60% after Deductible
<b>Preventive Health Care</b>		
Well Child Care (to age 6)	\$20 Copay	60% after Deductible
Annual Well Women Exam	\$20 Copay	60% after Deductible
Annual Mammography Exam	No Additional Copay	60% after Deductible
Annual Cervical Cancer Screening	No Additional Copay	60% after Deductible
Prostate Cancer Screening	No Additional Copay	60% after Deductible
Immunizations (to age 6)	No Additional Copay	60% after Deductible
<b>Services Received at a Facility (includes professional and facility charges)</b>		
Inpatient Services	80% after Deductible	60% after Deductible
Outpatient Services	80% after Deductible	60% after Deductible
Routine Diagnostic Services Outpatient	100% (no deductible)	60% after Deductible
Non-routine Diagnostic Services Outpatient	80% after Deductible	60% after Deductible

Provider-Administered Specialty Pharmacy Products	80% after Deductible	60% after Deductible
Other Outpatient Services	80% after Deductible	60% after Deductible
Emergency Care Services	80% after Deductible	80% after Deductible
Emergency Care Non-Routine Diagnostics	80% after Deductible	80% after Deductible
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Medical Equipment		
Durable Medical Equipment, Prosthetic, & Orthotic Appliances	80% after Deductible	60% after Deductible
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Therapeutic Services		
Therapy	80% after Deductible	60% after Deductible
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Skilled Nursing Facility & Rehabilitation Facility Services		
Limited to 60 days combined	80% after deductible	60% after Deductible
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Home Health Services		
Limited to 60 visits per year	80% after Deductible	60% after Deductible
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Hospice Service	100%	60% after Deductible
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Ambulance Services	80% after Deductible	60% after Deductible

**Notes (see benefit summary on prior page):**

1. HIPAA regulations apply. A Group enrollee's pre-existing condition waiting period can be reduced by the enrollee's applicable 'creditable coverage'.

2. Out-of-network benefit payment based on BlueCross BlueShield of Tennessee maximum allowable charge. You are responsible for paying any amount exceeding the maximum allowable charge.

3. Services require prior approval. Benefits will be reduced to 50% for services received from network providers outside Tennessee and all out-of-network providers when prior approval is not obtained.

4. Certain surgical procedures require prior approval. Benefits will be reduced to 50% for services received from network providers outside Tennessee and all out-of-network providers when prior approval is not obtained.

Call Customer Service to determine which procedures require prior approval.

5. CAT scans, MRIs, nuclear medicine and other similar technologies.

6. Includes services such as chemotherapy, radiation therapy, infusions, and renal dialysis.

7. ER services include all services in conjunction with ER visit except non-routine diagnostic services.

8. Physical, speech, manipulative, and occupational therapies are limited to 30 visits per therapy type per year. Cardiac and pulmonary rehabilitative therapies are limited to 36 visits per therapy type per year.

9. Requires prior approval.

10. Well Care Rider services are limited to \$300 per year.

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**PPO Benefit Exclusions:**

- routine transportation, supportive environmental equipment, maintenance or custodial care, social casework, or meal delivery
- homemaker or housekeeping services, meals, funeral or financial counseling
- office visits and physical exams for school, camp, employment, travel insurance, marriage or legal proceedings and related immunizations and tests
- second surgical opinions given by a practitioner in the same medical group as the practitioner who initially recommended the surgery
- routine foot care for the treatment of flat feet, corns, bunion, calluses, toenails, fallen arches, weak feet or chronic foot strain
- foot orthotics, shoe inserts and custom made shoes except for diabetic patients or as part of a leg brace
- custodial, domiciliary or private duty nursing services
- inpatient hospital stays primarily for therapy
- private duty nursing
- service which could be provided in a less intensive setting
- transportation for the sole convenience of the member
- transportation that is not essential to reduce the probability of harm to the patient
- ambulance services when the member is not transported to a facility
- services or supplies that are designed to medically enhance a member's level of fertility in the absence of a disease
- assisted reproductive technology (ART), such as *GIFT, ZIFT*, invitro-fertilization and fertility drugs
- services or supplies for the reversals of sterilizations
- elective abortions
- services, supplies or prosthetics primarily to improve appearance, including wigs or other hair prostheses or transplants
- surgeries in order to correct or repair the results of a prior surgical procedure, the primary purpose of which was to improve appearance
- surgeries and related services to change gender
- treatment beyond what can reasonably be expected to significantly improve health, including therapeutic treatments for ongoing maintenance or palliative care and duplicative therapies
- enhancement therapy which is designed to improve the member's physical status beyond their pre-injury or pre-illness state

- modalities that do not require the attendance or supervision of a licensed therapist, including activities which are primarily social or recreational in nature, simple exercise programs, hot and cold packs applied in the absence of associated therapy modalities, repetitive exercises or tasks which can be performed by the member without a therapist, in a home setting, routine dressing changes.
- behavioral therapy, play therapy, communication therapy and therapy for self-correcting language dysfunctions
- complementary and alternative therapeutic services whose value has not yet been determined to be medically necessary, including massage therapy, acupuncture, aquatic therapy, craniosacral therapy, neuromuscular reeducation, vision exercise therapy, and cognitive therapy
- charges exceeding the maximum allowable charge for the total cost of purchase of durable medical equipment
- unnecessary repair, adjustment or replacement or duplicates of any durable medical equipment
- supplies and accessories that are not necessary for the effective functioning of the covered medical equipment
- items to replace those which were lost, damaged, stolen or prescribed as a result of new technology
- motorized scooters, "deluxe" or "enhanced" equipment•
- contacts after the initial pair following cataract surgery
- hearing aids
- surgery or services as a result of an injury to the jaw, natural teeth, mouth, or face not completed within 12 months of the date of the accident
- treatment for routine dental care and related services including but not limited to replacement of teeth, bone grafts, treatment of teeth roots, treatment of injuries due to biting and chewing, crowns, plates, x-rays, fillings, removal of non-impacted teeth
- treatment for correction of underbite, overbite, and misalignment of the teeth, including orthognathic surgery and braces for dental indications
- behavioral health services except as listed in a separate rider
- services and supplies to detect or correct refractive errors of the eyes, except as listed in a separate rider
- eyeglasses, contact lenses and examinations for the fitting of eyeglasses and contact lenses, except as listed in a separate rider
- eye exercises and/or therapy
- visual training
- pharmaceuticals which may be purchased without a prescription
- pharmaceuticals purchased with a prescription except those dispensed at a participating facility, unless listed in a separate rider
- services or supplies not listed as a covered service in the Evidence of Coverage
- services or supplies that are determined to be not medically necessary or determined to be experimental or investigational in nature
- illness or injury resulting from war and covered by veteran's benefit or other coverage for which the member is legally entitled and which occurred before the member's coverage began under this contract.

- self treatment or training
- staff consultations required by hospital or other facility rules
- services which are free
- services or supplies related to any treatment or services resulting from the member's participation in a felony, riot, or insurrection
- treatment of work related illness or injury, regardless of the presence or absence of worker's compensation coverage, unless resulting from self-employment by a sole proprietor or partner of the insured group who had elected not be covered by the worker's compensation law
- personal and convenience items and services such as barber and beauty services, television, air conditioners, humidifiers, air filters, heaters, physical fitness equipment, saunas, whirlpools, water purifiers, swimming pools, tanning beds and other recreational equipment, weight loss programs, physical fitness programs or self-help devices which are not primarily medical in nature, even if ordered by a practitioner
- wellcare or other preventive services at age 6 or over, unless as listed in a wellcare rider, including but not limited to well-child care, periodic health assessments, immunizations, eye and ear examinations to determine the need for vision and hearing correction
- telephone or e-mail consultations, or charges for failure to keep a scheduled appointment, or handling fees
- services for providing requested medical information or completing forms
- court-ordered examinations and treatment
- room, board and general nursing care rendered on the date of discharge, unless admission and discharge occur on the same day
- any service stated in the Evidence of Coverage as a Non-Covered Service or Limitation
- charges in excess of the Maximum Allowable Charge for Covered Services or any charges which exceed the Lifetime Maximum or any other limitations listed under the Evidence of Coverage or its attachments
- services or supplies received in a dental or medical department maintained by or on behalf of the employer, mutual benefit association, labor union or similar group
- benefits for Pre-existing Conditions (until any pre-existing waiting periods have been met)
- organ transplants when prior approval through transplant case management is not obtained
- transplant related charges above the Transplant Maximum Allowable Charge removal of an organ from a member for purposes of transplantation into another person, except as covered by the donor organ procurement provision
- services performed by a family member
- nicotine replacement therapy and aids to smoking cessation including patches
- human growth hormones except for specific conditions shown in Evidence of Coverage
- safety items or items to affect performance primarily in sports related activities

- services and supplies related to obesity, including surgical or other treatment of morbid obesity
- cosmetic services including surgical or other services, drugs, or devices, including removal of tattoos, removal of moles, face-lifts, blepharoplasty, keloid removal, dermabrasion, chemical peels, rhinoplasty, breast augmentation and breast reduction
- services and charges related to the care of the biological mother of an adopted child, if the biological mother is not a member, surrogate parenting, sperm preservation
- treatment of sexual dysfunction, including erectile dysfunction (e.g. Viagra), delayed ejaculation, anorgasmia and decreased libido **\$10/\$30/\$45**

**Prescription Drug Plan**

<b>Generic Drugs</b>	<b>\$10 Copay</b> per prescription, up to 30 day supply
<b>Preferred Brand Name Drugs</b>	<b>\$35 Copay</b> per prescription, up to 30 day supply
<b>Non-preferred Brand Name Drugs</b>	<b>\$50 Copay</b> per prescription, up to 30 day supply

The copayment is the amount you pay to a network pharmacy for each prescription you have filled. Your copayment is dependent upon which brand level of drug you choose.

**Generic Drugs- your copay is \$10**

Generic drugs offer the best value. A generic drug is a safe and effective alternative to a brand name drug. You pay the lowest copay when you choose a generic drug. When your doctor writes your prescription, ask about using a generic drug.

Generic drugs are made with the same active ingredients and produce the same effects in the body as their brand-name equivalents. The difference? Just the name and price — and **generics cost less**. BlueCross BlueShield of Tennessee encourages the use of generic drugs by offering lower copayments when choosing generics.

**Preferred Brand Drugs- your copay is \$35**

You'll always save money when using generics. In fact, all you pay is the generic copay. But if your doctor prescribes a Preferred Brand drug, your copay is \$35. You may purchase a Preferred Brand drug even when a generic equivalent is available. However, if a generic equivalent is available and your doctor allows for substitutions, you will pay the generic copay plus the cost difference between the brand and generic drug. If your doctor does not allow substitutions, then you will pay the \$35 copay.

**Non-Preferred Brand Drugs- your copay is \$50**

When your doctor prescribes a brand drug that is not on the Preferred Drug list, you pay the highest copay of \$50. You may purchase a Non-Preferred Brand drug even when a generic equivalent is available. However, if a generic equivalent is available and your doctor allows for substitutions, you will pay the generic copay plus the cost difference between the brand and generic drug. If your doctor does not allow for substitutions, then you will pay the \$50 copay.

### **Pricing at Participating Pharmacies**

When a member receives a prescription at a pharmacy, he or she typically pays the appropriate copayment (either generic or brand under a two-tier plan; or generic, preferred brand or non-preferred brand under a three-tier plan). Members pay less than the copayment if the pharmacy's usual price for the drug is less than the copayment.

### **Limitations**

**These limitations apply to each prescription order.**

Benefits will be provided for

- up to a 30-calendar-day supply of prescription drugs (copay) and/or a 90-calendar-day supply of prescription drugs (2 times copay)
- up to a 90-calendar-day supply of maintenance prescription drugs listed on the BlueCross BlueShield of Tennessee maintenance drug list (2 times copay)
- up to a 90-calendar-day supply of prescription drugs obtained through home delivery ( 2 times copay)

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.

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.

### **Prescription Home Delivery**

Enjoy the convenience of prescription home delivery by calling 1-877-683-6837, or completing a Caremark.com mail order form. Simply mail the completed form along with the written prescription and payment in the Caremark.com envelope. For more information, visit the pharmacy section at [www.bcbstn.com](http://www.bcbstn.com).

### **Specialty Pharmacy Program**

Certain injectable medications for chronic illnesses can be ordered quickly and conveniently through the Specialty Pharmacy Program. Caremark Specialty Rx, CuraScript Pharmacy, and Priority Healthcare are experienced in managing high-cost drugs for conditions such as Hepatitis C, Multiple Sclerosis, Arthritis and Hemophilia.

#### **Caremark Specialty**

##### **Pharmacy Services**

1-866-295-2779 (phone)

1-866-295-2778 (fax)

##### **CuraScript Pharmacy**

1-888-773-7376 (phone)

1-888-773-7386 (fax)

##### **Priority Healthcare**

1-866-225-5670 (phone)

1-866-225-5671 (fax)

### **Out-of-Network Pharmacies**

If a prescription is filled at an out-of-network pharmacy, you must pay all costs. A claim can then be submitted to BlueCross BlueShield of Tennessee. Reimbursement is based on the BlueCross BlueShield of Tennessee allowed charge, less any applicable copay, deductible or coinsurance amount.

### **A Broad Network**

BlueCross BlueShield of Tennessee members access the Caremark network for retail pharmacy benefits. This network provides tremendous accessibility with over 56,000 pharmacies nationally and over 1,800 in Tennessee, including every national chain and many independent pharmacies. A directory of participating pharmacies is available online at [www.bcbstn.com](http://www.bcbstn.com).

### **BENEFITS WILL NOT BE PROVIDED FOR THE FOLLOWING:**

- Drugs for the treatment of onychomycosis (e.g. nail fungus), except for: 1) diabetics or 2) immunocompromised patients
- Growth hormones, except for:  
1) treatment of absolute growth hormone deficiency in children whose epiphyses have not closed; 2) patients with "Turner" syndrome; and 3) patients with Prader-Willi syndrome confirmed by appropriate genetic testing;
- Prescription and non-prescription medical supplies, devices and appliances, except for syringes used in conjunction with injectable medications or other supplies used in the treatment of diabetes and/or asthma;
- Immunizations or immunological agents, including but not limited to: 1) biological sera, 2) blood, 3) blood plasma; or 4) other blood products are not Covered, except for blood products required by hemophiliacs.
- Injectable drugs, unless: 1) intended for self-administration; or 2) defined by the Plan.
- 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 EOC;
- Any drugs, medications, Prescription devices or vitamins, available over-the-counter that do not require a Prescription by Federal or State law; except as otherwise Covered in the EOC;
- Any quantity of Prescription Drugs which exceeds that specified by the Plan's P & T Committee;
- Any Prescription Drug purchased outside the United States, except those authorized by Us;
- Any Prescription dispensed by or through a non-retail internet Pharmacy;
- Contraceptives which require administration or insertion by a Provider (e.g., non-drug devices, implantable products such as Norplant, except injectables), except as otherwise Covered in the EOC;
- Medications intended to terminate a pregnancy (e.g., RU-486);
- Non-medical supplies or substances, including support garments, regardless of their intended use;
- Artificial appliances;
- Allergen extracts;
- Any drugs or medicines dispensed more than one year following the date of the Prescription;
- Prescription Drugs You are entitled to receive without charge in accordance with any worker's compensation laws or any municipal, state, or federal program;

## **BENEFITS WILL NOT BE PROVIDED FOR: (con't)**

- Replacement Prescriptions resulting from lost, spilled, stolen, or misplaced medications (except as required by applicable law);
- Administration or injection of any drugs;
- Prescription Drugs used for the treatment of infertility;
- Prescription Drugs not on the Drug Formulary;
- Anorectics (any drug or medicine for the purpose of weight loss and appetite suppression);
- Nicotine replacement therapy and aids to smoking cessation including, but not limited to, patches;
- All newly FDA approved drugs prior to review by the Plan's P & T Committee;
- Any Prescription Drugs or medications used for the treatment of sexual dysfunction, including but not limited to erectile dysfunction (e.g. Viagra), delayed ejaculation, anorgasmia and decreased libido;
- 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;
- FDA approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia;
- Drugs dispensed by a Provider other than a Pharmacy;
- Compound drugs filled or refilled at an Out-of-Network Pharmacy;
- Drugs used to enhance athletic performance;
- Experimental and/or investigational Drugs; and
- Provider-administered Specialty Pharmacy Products, as indicated on Our Specialty Pharmacy Products list.
- Prescription Drugs or refills dispensed:
  1. in quantities in excess of amounts specified in the BENEFIT PAYMENT section;
  2. without Our Prior Authorization when required; or
  3. which exceed any applicable Annual Maximum Benefit, or any other maximum benefit amounts stated in this Rider or the EOC.

## Extended Well Care

To maintain your health throughout your life, you should receive the proper tests and immunizations at the appropriate time and frequency. Many factors, including your age, gender, family history, and other special needs, determine when particular services are beneficial. Therefore you should discuss with your physician what is right for you.

**You and each eligible dependent over the age of 6 may receive preventative health services, not to exceed \$300 per calendar year.\*** All services must be medically necessary and appropriate and recommended by the U.S. Preventative Health Task Force, or in conjunction with the plan's preventative health care guidelines

All well care benefits listed are subject to the terms, conditions, limitations, and exclusions contained in the Group Master contract and the Evidence of Coverage.

**All services covered by the Wellcare rider are subject to normal contract benefits, which are determined by type of service and place of service.\***

The following is a list of items that are covered as a part of the annual preventative health exam for persons over the age of 6:

- Annual Health Assessment
- Childhood immunizations
- Blood pressure screening
- Periodic cholesterol screening
- Periodic colorectal cancer screening, not subject to the \$300 calendar year limit\*
- Flu shot
- Tetanus-diphtheria (TD) booster
- Pneumococcal immunization
- Other recommended adult immunizations and immunizations not completed in childhood
- Other prescribed x-ray and lab screenings associated with preventative care
- Vision and hearing screenings performed by the physician during the preventative health exam

Most of these services are not needed every year, or may be appropriate only for people of particular age groups, genders, or those who meet other specific health criteria.

***Please Note: This benefit summary is only a brief description of PPO benefits. All benefit determinations are governed by the Master Contract on file with the employer.***

