STATE OF TENNESSEE

# 2023 Member Handbook

State | Higher Education | Local Education | Local Government
Premier PPO | Standard PPO | Limited PPO | CDHP/HSA | Local CDHP/HSA

of Tennessee

PARTNERS FOR HEALTH

# Table of Contents

# Important Reminders

- **Your health coverage is effective Jan. 1, 2023, through Dec. 31, 2023 , subject to eligibility.** You won't be able to change plans or networks during this time. You may be able to make changes allowed by the plan if you have a qualifying event. A provider or hospital leaving a network is not a qualifying event.
- **Benefit Grids on pages 12 – 14 outline your responsibility for your cost share of medical expenses.** Your cost share applies even if this plan is your secondary coverage. See the Coordination of Benefits section on page 24 for more details.
- **Take care when signing medical waivers** or other documents that might make you financially responsible for unpaid charges.
- **See the "If You Have Questions" section on page 8 and make contact as soon as possible.** A delay could cause you to miss important deadlines.
- **You have rights and protections against surprise medical bills.**
  When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. For more information, see the important notice about surprise medical bills at **https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/surprise_billing_model_notice.pdf**.

# Benefit Highlights

**Members have three separate ID cards for medical services, behavioral health/substance use disorder services and pharmacy services.** The back of each card has a specific customer service number. Using the correct card and calling the number on that card will improve your customer service experience.

## Medical – Call 1-800-558-6213 for more information

- **Cost savings for approved transplants at certain preferred transplant facilities***
  - BCBS Blue Distinction Center of Excellence Transplant Facilities
  - In-Network facilities when there is no BCBS Blue Distinction COE option
  - PPO members – no cost; deductible and coinsurance are waived
  - CDHP members – no cost after deductible; coinsurance is waived
- **Provider-administered specialty medications outreach**
  Some medications are given to you in an office or outpatient setting for chronic, serious diseases such as hepatitis C and arthritis. Your doctor will take care of approvals and order these medications for you. You may get a call from a pharmacy vendor or your doctor´s office to gather more information if you need one of these medications. If you get a call, it's important that you provide what is asked of you. Doing so will allow the order for your medication to be filled without delay. You will pay your usual cost share (copay or deductible and coinsurance) for your medication, and your provider will give it to you. This program will not result in any change to pharmacy benefits administered by CVS Caremark.
- **Vaccines will continue to be covered at 100%.**
  Vaccines are covered for flu and other diseases.

# Programs and Resources – See more at **bcbst.com/tn_state**

› **Member Discounts**
- Our member discounts program helps you save on health-related purchases like eyewear, nutrition programs, gym memberships and fitness gear.

› **Identity Protection**
- Your benefits include Experian identity protection services at no extra cost to you. These services help keep your personal information safe.

› **BCBSTN℠ Mobile App**
- See an overview of your benefits, get one-on-one support using our chat feature and more. You can also do this with your online account.

› **Teladoc™ Health**
- Get 24/7 virtual health care services at home or on the road with Teladoc Health.

› **Diabetes Prevention Program**
- If you're eligible, you can enroll in the diabetes prevention program for healthy living tips, health coaching and more.

› **Consumer Medical**
- If you have a serious medical condition or are considering treatment options, you can get a second opinion from a team of experts.

› **Hinge Health**
- You and your eligible family members can get help for back and joint pain with a personalized exercise therapy program from the comfort of home.

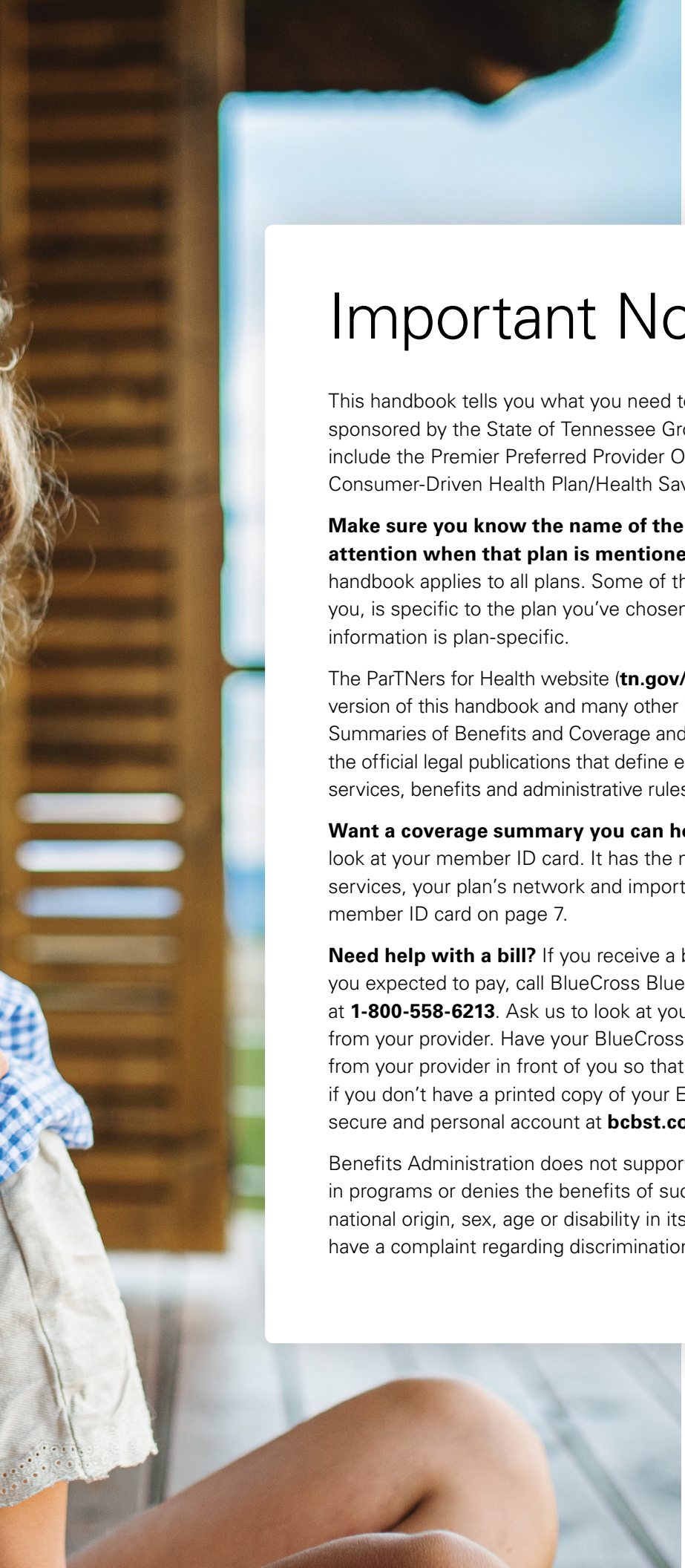
## Behavioral Health and Substance Use – Claims are processed under behavioral health benefits. If you have questions, call Optum Behavioral Health at 1-855-437-3486 for more information

› **Cost savings for facility-based treatment at certain preferred substance use (alcohol/drug) treatment facilities*:**
- Find preferred Optum providers by calling **1-855-Here4TN (1-855-437-3486)** or visiting **Here4TN.com**
- PPO members – no cost; deductible and coinsurance are waived
- CDHP members – no cost after deductible; coinsurance is waived
- Cost sharing still applies for standard outpatient treatment services

## Pharmacy – Claims are processed under pharmacy benefits. If you have questions, call CVS Caremark at 877-522-8679 for more information

› **Cost savings for 90-day supply of certain maintenance medications from 90-day network pharmacy or mail order**
- Maintenance medications include certain antihypertensives for coronary artery disease and congestive heart failure; oral diabetic medications, insulin and diabetic supplies; statins; medications for asthma, COPD (emphysema and chronic bronchitis), depression and some osteoporosis medications.
- PPO and CDHP plan members can receive a 90-day supply of maintenance medications for the same cost as a 30-day supply (generic and preferred brands only). For CDHP members, these maintenance medications bypass the deductible and you pay the lower, discounted cost immediately.

* See "Benefit Grids," "Covered Medical Expenses" and "How The Plan Works" sections in this handbook on pages 12, 17 and 19 respectively for more details. Standard benefits will apply when members elect treatment at non-preferred facilities. Prior authorization is required for inpatient care.



# Important Notices

This handbook tells you what you need to know about ALL medical plans sponsored by the State of Tennessee Group Insurance Program. Those plans include the Premier Preferred Provider Organization, Standard PPO, Limited PPO, Consumer-Driven Health Plan/Health Savings Account, and Local CDHP/HSA.

**Make sure you know the name of the plan you've chosen, and pay special attention when that plan is mentioned.** Much of the information in this handbook applies to all plans. Some of the information, like what services will cost you, is specific to the plan you've chosen. You'll see plan names mentioned when information is plan-specific.

The ParTNers for Health website (**tn.gov/partnersforhealth**) contains an electronic version of this handbook and many other important publications, including Summaries of Benefits and Coverage and Plan Documents. The Plan Documents are the official legal publications that define eligibility, enrollment, covered and excluded services, benefits and administrative rules of the State Group Insurance Program.

**Want a coverage summary you can hold in the palm of your hand?** Take a look at your member ID card. It has the name of your plan, your cost for common services, your plan's network and important phone numbers. See a sample member ID card on page 7.

**Need help with a bill?** If you receive a bill for medical services that is more than you expected to pay, call BlueCross BlueShield of Tennessee Member Service at **1-800-558-6213**. Ask us to look at your claim and discuss the bill you received from your provider. Have your BlueCross explanation of benefits (EOB) and the bill from your provider in front of you so that we can review them together. No worries if you don't have a printed copy of your EOB. You can find it by signing in to your secure and personal account at **bcbst.com/tn_state/**.

Benefits Administration does not support any practice that excludes participation in programs or denies the benefits of such programs on the basis of race, color, national origin, sex, age or disability in its health programs and activities. If you have a complaint regarding discrimination, please call **(615) 532-9617**.

# Welcome

## State, higher education, local education and local government members:

Thank you for choosing BlueCross. We've been working in Tennessee for more than 75 years to provide quality, affordable health care. Today, more than 3 million people nationwide turn to us for health care coverage.

We're also part of the Blue Cross Blue Shield Association, a nationwide association of health care plans. Because of this, our plan members have access to the same quality health benefits while traveling or living out of state. So no matter where you live, work or travel, you can find an in-network provider when you need care. We're right here to answer any questions, help you understand your coverage and make sure you get the care you need.

# Member ID Cards

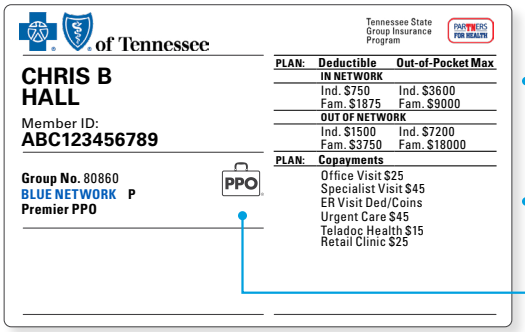
You have ID cards for yourself and each of your covered dependents. All cards list your name as the employee or head of contract. The cards show your health plan and network. Your network is either **Blue Network S℠** or **Blue Network P℠**. Review this information carefully and call if you have any questions.

**See your actual Member ID card.**

Your Blue Network℠ letter (S or P) identifies your network

The name of your plan will appear in this field. You'll see one of the following:

- Premier PPO
- Standard PPO
- Limited PPO
- CDHP/HSA
- Local CDHP/HSA




Front

Annual deductible and out-of-pocket maximum amounts

In-network amounts (copayment or coinsurance) for various health care services

The suitcase icon means your plan covers you throughout the U.S. and many countries.*


Back

Prior authorization instructions

Member Service phone number

The number to call if you're outside Tennessee

Prior authorization contact information including hospitals, advanced imaging services, etc.

Other important numbers

## Where´s my Member ID card?

- You´ll get two new ID cards for 2023 if you´re a continuing BlueCross member. You´ll also receive two additional cards for every dependent on your plan over the age of 18.
- You will also receive ID cards if you are a new BlueCross member, if you add dependents or if you elect a different medical plan design option.
- You can print temporary cards or request replacement cards by logging in to your account at **bcbst.com**.
- You can see a digital version of your card on our **BCBSTN**℠ app.

* Check for details in your Summary of Plan document (SPD), policy or in your bcbst.com account

# Network Choices

BlueCross BlueShield offers two network options for plan members. Your choice of network affects your monthly premium cost.

- **Network S** has many providers and facilities across Tennessee. There is no additional premium charge when you select this network.
- **Network P** is a larger network with more doctors and facilities than Network S. A higher monthly premium applies if you select this network.

**Your health coverage is effective January 1, 2023, through December 31, 2023, subject to eligibility.** You won't be able to change plans or networks for 2023. You may be able to make changes allowed by the plan if you have a qualifying event. **A provider or hospital leaving a network is not a qualifying event.**

# Plan Administration and Claims Administration

Benefits Administration, a division of the Department of Finance and Administration, is the plan administrator, and BlueCross BlueShield of Tennessee is the claims administrator. This program uses the benefit structure approved by the Insurance Committee that governs the plan. When claims are paid under this plan, they are paid from a fund made up of your premiums and the employer contributions. BlueCross BlueShield of Tennessee is contracted by the state to process claims, establish and maintain provider networks and conduct utilization management reviews.

Claims paid in error for any reason may be recovered from the employee. Filing false or altered claim forms constitutes fraud and is subject to criminal prosecution. You may report possible fraud at any time by contacting Benefits Administration.

# If You Have Questions:

- about eligibility or enrollment (e.g., becoming insured, adding dependents, when your coverage starts, transferring between plans, ending coverage), contact your agency benefits coordinator. They will work with Benefits Administration to help you.
- about health coverage (e.g., prior authorization, claims processing or payment, bills, benefit statements or letters from your health care provider or BlueCross BlueShield), contact BlueCross BlueShield Member Service at **1-800-558-6213**. See also information at the end of this handbook about your appeal rights.

# Adding Dependents

If you want to add dependents to your coverage, you must provide documentation verifying the dependents' eligibility to Benefits Administration. A list of acceptable documents is available from your agency benefits coordinator or the ParTNers for Health website.

# Important Contact Information

We're here to answer any questions about your health coverage or specific health care claims. Call member services to speak with someone who can explain how your specific benefits and coverage work. You'll need your Member ID card when you call.

**BlueCross BlueShield of Tennessee Member Service: 1-800-558-6213** | 7 a.m. – 5 p.m. (CT) M-F
Report Fraud: 1-888-343-4221
Transplant Coordinator: 1-888-207-2421

**Find in-network providers while traveling:**

- Anywhere in the United States, call 1-800-810-BLUE (2583) or visit **bcbsglobalcore.com**
- Anywhere outside the United States, call 1-800-810-BLUE (2583) toll-free or (804) 673-1177 collect, or visit **bcbsglobalcore.com**

**Mailing address for claims:**
BlueCross BlueShield of Tennessee
Claims Service Center
1 Cameron Hill Circle Ste 0002
Chattanooga, TN 37402-0002

**Mailing address for pre-determination requests:**
BlueCross BlueShield of Tennessee
Predeterminations/ODM, 2G
1 Cameron Hill Circle Ste 0014
Chattanooga, TN 37402-0014

**Mailing address for Unique Care, Transition of Care and Continuity of Care exception requests:**
BlueCross BlueShield of Tennessee
State Unique Care/Continuous Care
1 Cameron Hill Circle
Chattanooga, TN 37402

**Behavioral Health, Substance Use, and Employee Assistance Program**
Optum Behavioral Health
1-855-Here4TN (1-855-437-3486)
**Here4TN.com**

**Pharmacy**
CVS Caremark
1-877-522-8679
**info.caremark.com/stateoftn**

**HSA/FSA**
Optum Financial
1-866-600-4984
**optumbank.com/Tennessee**

**ParTNers for Health Wellness Program**
1-888-741-3390
**go.activehealth.com/wellnesstn**

**Your Online Account**
Register or log in to your account at **bcbst.com/tn_state**.

With your online account, you can:
- Find providers in your network
- Check your benefits and claims
- Explore tools and programs that can help you make healthy lifestyle changes

Check back often to see what's new.

# Cost Sharing

The term cost sharing means your share of costs, or what you must pay out of your own pocket, for services covered by your health plan. Sometimes these costs are called out-of-pocket costs. Some examples of cost sharing are copayments, deductibles and coinsurance. Other costs, including your premiums or the cost of care not covered by your plan, aren't considered cost sharing.

Your cost sharing is less for in-network care. You have separate out-of-network cost-sharing amounts for eligible services from out-of-network providers.

A **copayment** (or copay) is a fixed amount you pay for a covered health care service, usually when you receive the service. An example of a copayment is $25.

**Coinsurance** is your share of the cost of a covered health care service, calculated as a percentage. An example of coinsurance is 20% of the allowed amount for a service. Generally, if coinsurance applies to a health care service, you will have to "meet" or "satisfy" a deductible first. In other words, you will pay your deductible **plus** coinsurance.

A **deductible** is the amount you pay each plan year for certain covered health care services before your plan pays for those services. Eligible medical, pharmacy and behavioral health expenses count toward your deductible. Ineligible expenses, including amounts that exceed the maximum allowable charge, are not applied to the deductible. A deductible applies to some services under the state-sponsored PPO plans and almost all services under the state-sponsored CDHP/HSA plans.

There are in-network and out-of-network deductibles. The two deductibles add up separately. In-network charges cannot be applied to an out-of-network deductible, and out-of-network charges cannot be applied to an in-network deductible.

**For PPO plans**, members in a family plan DO have an individual deductible equal to the "employee only" amount.

**For CDHP plans**, members in a family plan DO NOT have an individual deductible limit. Each family member will contribute to the overall family deductible which must be met before the plan pays for any family member's claims subject to a deductible.

Copayment, coinsurance and deductible amounts vary depending on the plan you've chosen and the type of services you receive.

An **out-of-pocket maximum** limits how much you pay in any year. If your spending reaches the out-of-pocket maximum, the plan pays 100% of your eligible expenses for the rest of the year. Your eligible cost-sharing amounts, including your deductible, count toward your annual out-of-pocket maximum.

**For PPO plans**, members in a family plan DO have an individual out-of-pocket maximum amount equal to the "employee only" amount.

**For the CDHP/HSA plan**, state and higher education members in a family plan DO NOT have an individual out-of-pocket limit. Each family member will contribute to the overall family out-of-pocket amount which must be met before the plan covers the family's eligible in-network expenses at 100% for the remainder of the plan year.

**For the Local CDHP/HSA plan**, local education and local government members in a family plan DO have an individual out-of-pocket limit FOR IN-NETWORK EXPENSES. No one family member will pay more than $8,700 toward their in-network out-of-pocket limit. Once a family member has eligible in-network out-of-pocket costs totaling $8,700, the plan will cover that family member's eligible in-network expenses at 100% for the remainder of the plan year. All other family members will contribute to the remaining overall family out-of-pocket limit which must be met before the plan covers the family's eligible in-network expenses at 100% for the remainder of the plan year.

See the Benefit Grids in this handbook for out-of-pocket limits.

**Note:** There are separate out-of-pocket maximums for in-network and out-of-network expenses. As with the deductible, in-network charges cannot be applied to an out-of-network out-of-pocket maximum, and out-of-network charges cannot be applied to an in-network out-of-pocket maximum. Charges in excess of the maximum allowable charge and non-covered expenses do not count toward the out-of-pocket maximum.

# PPO Plans

A PPO plan is a preferred provider organization plan. It requires that you pay either a copayment or a deductible and coinsurance for covered services.

Whether you're enrolled in the Premier PPO, the Standard PPO or the Limited PPO:

- In-network preventive care (annual well visit and routine screenings) is covered at no cost to you.
- You pay copays for other covered services like:
  - office visits to primary care providers and specialists
  - behavioral health and substance use services
  - telehealth
  - visits to convenience clinics
  - urgent care facilities, and
  - most prescription medications
- You pay deductible and coinsurance for things like:
  - emergency rooms
  - ambulance services
  - inpatient hospital care
  - outpatient surgery
  - advanced imaging, and
  - durable medical equipment

# CDHP Plans

A CDHP includes a tax-free Health Savings Account, which you own and can use to pay for qualified medical expenses. Qualified expenses may include things that may not be covered by your health insurance plan, like vision and dental expenses, hearing aids, contact lens supplies and more. More information follows in the HSA section of this handbook.

Whether you're enrolled in the CDHP/HSA or the Local CDHP/HSA:

- In-network preventive care (annual well visit and routine screenings) is covered at no cost to you.
- You pay coinsurance for ALL other covered services.
- You must meet your deductible before the plan pays for covered expenses, EXCEPT for in-network preventive care and 90-day supply maintenance medications (e.g., certain medications to treat high blood pressure, diabetes, depression, high cholesterol, etc.).
- Your cost for prescription medications is the discounted network rate for the prescriptions until the deductible is met. Then you pay your coinsurance, which is a percentage of the discounted network rate.
- If you buy your prescriptions by mail order and want to use your HSA funds to pay, you must provide Caremark with your HSA debit card number before the prescription is filled and shipped. Otherwise, Caremark will charge the order to the credit card they have on file.

# Health Savings Account

When you enroll in a CDHP, an HSA will be opened for you automatically. The HSA is managed by **Optum Financial**, a company contracted by the state. Contact information is under the "Important Contact Information" section of this handbook. You own your HSA account, and it is your responsibility to register for your online account access at **optumbank.com/Tennessee**. The state will pay the monthly fee for your HSA while you are enrolled in the state's CDHP. You must pay standard banking fees such as an ATM fee each time you use your HSA debit card at an ATM. If you leave your job, retire or choose a PPO option in the future, you must pay the monthly HSA fees. These fees will be taken from your HSA automatically.

You and your employer may put money into your HSA. The money saved in your HSA (both yours and any employer contributions) rolls over each year and collects interest. You don't lose it at the end of the year. The money is yours! You take your HSA with you if you leave or retire.

- You can put money into your HSA with an online bank transfer or by mailing a check, or your employer may offer payroll deduction.
- In 2023, IRS guidelines allow total annual tax-free contributions up to $3,850 for those with single coverage and $7,750 for those with any other coverage. At age 55 and older, you can make an additional $1,000/year contribution ($4,850 for individuals or $8,750 for families). The maximum includes any employer contribution.
- If you have questions about employer contributions, contact your human resources office or your agency benefits coordinator.
- Your full HSA contribution is not available up front at the beginning of the year or after you enroll. Your pledged amount is taken out of each paycheck each pay period (if payroll deduction is offered by your employer). You may only spend the money that is available in your HSA at the time of service or care.

You can use money in your account to pay your deductible and qualified medical, behavioral health, vision and dental expenses. Once funds are in your HSA, it's easy to pay for your eligible expenses.

- Use the Optum Financial Card®, your account debit card. It's a convenient way to pay for eligible expenses. Expenses are paid automatically, as long as funds are available. If you have family coverage, additional debit cards may be ordered online or by phone.
- Use Optum Financial's online feature to pay your provider directly from your account.
- Pay yourself back: Pay for eligible expenses with cash, check or your personal credit card. Then withdraw funds from your HSA to pay yourself back. You can even have your payment deposited directly into your linked checking or savings account.

# Optum Financial Free Mobile App

- This app makes it easy for you to manage your account virtually 24/7. It's available for iPhone® and iPad® mobile digital devices, Android® and BlackBerry® smartphones. It will give you access to your online account to transfer funds, make payments or view a list of qualified medical expenses. It even lets you upload photos of your receipts for qualified expenses to keep for tax purposes.
- Both employee and employer contributions (if offered) are tax free. Withdrawals for qualified medical expenses are tax free. Interest accrued on your HSA balance is tax free.

**Note:** Payroll deductions are made before tax. Contributions made directly from employees' bank accounts need to be recorded as a tax deduction.

Go to **tn.gov/partnersforhealth** under Health Options and CDHP/HSA Insurance Options to learn more.

# Benefit Grid

## PPO Plans

**TABLE 1 Member Costs:** Services in this table **ARE NOT** subject to a deductible. The Limited is open to Local Education and Local Government members only.

| PPO HEALTH CARE OPTION | PREMIER | | STANDARD | | LIMITED | |
|---|---|---|---|---|---|---|
| **COVERED SERVICES** | In-Network[1] | Out-of-Network[1] | In-Network[1] | Out-of-Network[1] | In-Network[1] | Out-of-Network[1] |
| **Preventive Care Office Visits** | | | | | | |
| Well-baby, well-child visits as recommended<br>Adult annual physical exam<br>Annual well-woman exam<br>Immunizations as recommended<br>Annual hearing and non-refractive vision screening<br>Screenings including Pap smears, labs, nutritional guidance, tobacco cessation counseling and other services as recommended | No Charge | $45 | No Charge | $50 | No Charge | $50 |
| **Outpatient Services** | Services subject to a coinsurance may be extra | | | | | |
| **Primary Care Office Visit** | | | | | | |
| Family practice, general practice, internal medicine, OB/GYN and pediatrics<br>Provider-based telehealth<br>Nurse practitioners, physician assistants and nurse midwives (licensed health care facility only) working under the supervision of a primary care provider<br>Including surgery in office setting and initial maternity visit | $25 | $45 | $30 | $50 | $35 | $55 |
| **Specialist Office Visit** | | | | | | |
| Including surgery in office setting<br>Provider-based telehealth<br>Nurse practitioners, physician assistants and nurse midwives (licensed health care facility only) working under the supervision of a specialist | $45 | $70 | $50 | $75 | $55 | $80 |
| **Behavioral Health and Substance Use** (including virtual visits)[2] | $25 | $45 | $30 | $50 | $35 | $55 |
| **Telehealth Carrier Program** (Teladoc Health) | $15 | N/A | $15 | N/A | $15 | N/A |
| **Allergy Injection Without an Office Visit**<br>Allergy Serum has additional member cost | 100% covered | 100% covered up to MAC | 100% covered | 100% covered up to MAC | 100% covered | 100% covered up to MAC |
| **Chiropractic and Acupuncture** (limit of 50 visits of each per year) | Visits 1-20: $25<br>Visits 21-50: $45 | Visits 1-20: $45<br>Visits 21-50: $70 | Visits 1-20: $30<br>Visits 21-50: $50 | Visits 1-20: $50<br>Visits 21-50: $75 | Visits 1-20: $35<br>Visits 21-50: $55 | Visits 1-20: $55<br>Visits 21-50: $80 |
| **Convenience Clinic** | $25 | $45 | $30 | $50 | $35 | $55 |
| **Urgent Care Facility** | $45 | $70 | $50 | $75 | $55 | $80 |
| **Pharmacy** | | | | | | |
| **30-Day Supply** (generic \| preferred brand \| non-preferred) | $7 \| $40 \| $90 | copay plus amount exceeding MAC | $14 \| $50 \| $100 | copay plus amount exceeding MAC | $14 \| $60 \| $110 | copay plus amount exceeding MAC |
| **90-Day Supply** (generic \| preferred brand \| non-preferred) | | | | | | |
| 90-day network pharmacy or mail order | $14 \| $80 \| $180 | N/A – no network | $28 \| $100 \| $200 | N/A – no network | $28 \| $120 \| $220 | N/A – no network |
| Certain maintenance medications from 90-day network pharmacy or mail order[3] | $7 \| $40 \| $160 | N/A – no network | $14 \| $50 \| $180 | N/A – no network | $14 \| $60 \| $200 | N/A – no network |
| **Specialty Medication Tier 1** (generics; 30-day supply from a specialty network pharmacy) | In-Network for all plans = 20%; minimum $100; maximum $200<br>Out-of-Network for all plans = NA – no network | | | | | |
| **Specialty Medication Tier 2** (all brands; 30-day supply from a specialty network pharmacy) | In-Network for all plans = 30%; minimum $200; maximum $400<br>Out-of-Network = NA – no network | | | | | |

**TABLE 2 Member Costs:** Services in this table **ARE** subject to a deductible unless noted with a [5].
The Limited is open to Local Education and Local Government members only.

| PPO HEALTH CARE OPTION | PREMIER | | STANDARD | | LIMITED | |
|---|---|---|---|---|---|---|
| **COVERED SERVICES** | In-Network[1] | Out-of-Network[1] | In-Network[1] | Out-of-Network[1] | In-Network[1] | Out-of-Network[1] |
| **Preventive Care – Outpatient Facilities** | | | | | | |
| Recommended screenings such as colonoscopy, mammogram, colorectal and bone density scans | No Charge [5] | 40% | No Charge [5] | 40% | No Charge [5] | 50% |
| **Other Services** | | | | | | |
| **Hospital/Facility Services**[4] | | | | | | |
| Inpatient care[7]; outpatient surgery[7]; Inpatient behavioral health/substance use[2] [6] | 15% | 40% | 20% | 40% | 30% | 50% |
| Emergency room services[7] | 15% | | 20% | | 30% | |
| **Maternity** (Global billing for labor and delivery and routine services beyond initial office visit) | 15% | 40% | 20% | 40% | 30% | 50% |
| **Home Care**[4] (Home health; home infusion therapy) | 15% | 40% | 20% | 40% | 30% | 50% |
| **Rehabilitation and Therapy Services** | | | | | | |
| Inpatient and skilled nursing facility[4];Outpatient PT/ST/OT/ABA[5]; Other therapy | 15% | 40% | 20% | 40% | 30% | 50% |
| **X-Ray, Lab and Diagnostics** (not including advanced X-rays, scans and imaging)[5] | 15% | | 20% | | 30% | |
| **Advanced X-Ray, Scans and Imaging** (including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies)[4] | 15% | 40% | 20% | 40% | 30% | 50% |
| **Pathology and Radiology Reading, Interpretation and Results**[5] | 15% | | 20% | | 30% | |
| **Ambulance** (medically necessary air and ground) | 15% | | 20% | | 30% | |
| **Equipment and Supplies**[4] | | | | | | |
| Durable medical equipment and external prosthetics Other supplies (i.e. ostomy, bandages, dressings) | 15% | 40% | 20% | 40% | 30% | 50% |
| **Allergy Serum** | 15% | 40% | 20% | 40% | 30% | 50% |
| **Also Covered** | Certain limited **dental** benefits, **hospice care** and **out-of-country charges** – See separate sections in this handbook for details | | | | | |
| **Deductible - ONLY ELIGIBLE EXPENSES COUNT TOWARD THE DEDUCTIBLE** | | | | | | |
| Employee Only | $750 | $1,500 | $1,300 | $2,600 | $1,800 | $3,600 |
| Employee + Child(ren) | $1,125 | $2,250 | $1,950 | $3,900 | $2,500 | $4,800 |
| Employee + Spouse | $1,500 | $3,000 | $2,600 | $5,200 | $2,800 | $5,500 |
| Employee + Spouse +Child(ren) | $1,875 | $3,750 | $3,250 | $6,500 | $3,600 | $7,200 |
| **Out-of-Pocket Maximum - MEDICAL AND PHARMACY COMBINED - ELIGIBLE EXPENSES, INCLUDING DEDUCTIBLE COUNT** | | | | | | |
| Employee Only | $3,600 | $7,200 | $4,400 | $8,800 | $6,800 | $13,600 |
| Employee + Child(ren) | $5,400 | $10,800 | $6,600 | $13,200 | $13,600 | $27,200 |
| Employee + Spouse | $7,200 | $14,400 | $8,800 | $17,600 | $13,600 | $27,200 |
| Employee + Spouse +Child(ren) | $9,000 | $18,000 | $11,000 | $22,000 | $13,600 | $27,200 |

For PPO plans, no single family member will be subject to a deductible or out-of-pocket maximum greater than the "employee only" amount. Once two or more family members (depending on premium level) have met the total deductible and/or out-of-pocket maximum, it will be met by all covered family members.

[1] Subject to maximum allowable charge (MAC). The MAC is the most a plan will pay for a covered service. For non-emergent care from an out-of-network provider who charges more than the MAC, you will pay the copay or coinsurance PLUS the difference between MAC and actual charge, unless otherwise specified by state or federal law.

[2] The following behavioral health services are treated as "inpatient" for the purpose of determining member cost-sharing: residential treatment, partial hospitalization/day treatment programs and intensive outpatient therapy. In addition to services treated as "inpatient," prior authorization (PA) is required for certain outpatient behavioral health services including, but not limited to, applied behavioral analysis, transcranial magnetic stimulation, electroconvulsive therapy, psychological testing, and other behavioral health services as determined by the Contractor's clinical staff.

[3] List of eligible medication classes and a list of participating Retail-90 pharmacies can be found at https://www.tn.gov/partnersforhealth/health-options/pharmacy.html.

[4] Prior authorization (PA) required for non-emergent services. When using out-of-network providers, benefits for non-emergent medically necessary services will be reduced by half if PA is required but not obtained, subject to the maximum allowable charge. If services are not medically necessary, no benefits will be provided.

[5] Deductible DOES NOT apply.

[6] Select Substance Use Treatment Facilities are preferred with an enhanced benefit - members won't have to pay a deductible or coinsurance for facility-based substance use treatment; Copays will apply for standard outpatient treatment services. Call 855-Here4TN for assistance.

[7] In-network benefits apply to certain out-of-network professional services at certain in-network facilities.

# Benefit Grid

## CDHP Plans

**TABLE 1 Member Costs:** Services in this table **ARE** subject to a deductible with the exception of in-network preventive care and 90-day supply maintenance medications.

| CDHP/HSA HEALTH CARE OPTION | CDHP/HSA State and Higher Education | | LOCAL CDHP/HSA Local Education & Local Government | |
|---|---|---|---|---|
| **COVERED SERVICES** | In-Network[1] | Out-of-Network[1] | In-Network[1] | Out-of-Network[1] |
| **Preventive Care Office Visits** | | | | |
| Well-baby, well-child visits as recommended<br>Adult annual physical exam<br>Annual well-woman exam<br>Immunizations as recommended<br>Annual hearing and non-refractive vision screening<br>Screenings including Pap smears, labs, nutritional guidance, tobacco cessation counseling and other services as recommended | No Charge | 40% | No Charge | 50% |
| **Outpatient Services** | | | | |
| **Primary Care Office Visit** | | | | |
| Family practice, general practice, internal medicine, OB/GYN and pediatrics<br>Provider-based telehealth<br>Nurse practitioners, physician assistants and nurse midwives (licensed health care facility only) working under the supervision of a primary care provider<br>Including surgery in office setting and initial maternity visit | 20% | 40% | 30% | 50% |
| **Specialist Office Visit** | | | | |
| Including surgery in office setting<br>Provider-based telehealth<br>Nurse practitioners, physician assistants and nurse midwives (licensed health care facility only) working under the supervision of a specialist | 20% | 40% | 30% | 50% |
| **Behavioral Health and Substance Use**[2] (including virtual visits) | 20% | 40% | 30% | 50% |
| **Telehealth Carrier Program** (Teladoc Health) | 20% | N/A | 30% | N/A |
| **Allergy Injection Without an Office Visit**<br>Allergy Serum has additional member cost | 20% | 40% | 30% | 50% |
| **Chiropractic and Acupuncture** (limit of 50 visits of each per year) | 20% | 40% | 30% | 50% |
| **Convenience Clinic** | 20% | 40% | 30% | 50% |
| **Urgent Care Facility** | 20% | 40% | 30% | 50% |
| **Pharmacy** | | | | |
| **30-Day Supply** (generic \| preferred brand \| non-preferred) | 20% | 40% plus amount exceeding MAC | 30% | 50% plus amount exceeding MAC |
| **90-Day Supply** (generic \| preferred brand \| non-preferred) | | | | |
| 90-day network pharmacy or mail order | 20% | N/A – no network | 30% | N/A – no network |
| Certain maintenance medications from 90-day network pharmacy or mail order[3] | 10% without first having to meet deductible | N/A – no network | 20% without first having to meet deductible | N/A – no network |
| **Specialty Medication Tier 1** (generic; 30-day supply from a specialty network pharmacy) | 20% | N/A – no network | 30% | N/A – no network |
| **Specialty Medication Tier 2** (all brands; 30-day supply from a specialty network pharmacy) | 20% | N/A – no network | 30% | N/A – no network |

**TABLE 2 Member Costs:** Services in this table **ARE** subject to a deductible with the exception of in-network preventive care.

| CDHP/HSA HEALTH CARE OPTION | CDHP/HSA State and Higher Education | | LOCAL CDHP/HSA Local Education & Local Government | |
|---|---|---|---|---|
| **COVERED SERVICES** | In-Network[1] | Out-of-Network[1] | In-Network[1] | Out-of-Network[1] |
| **Preventive Care – Outpatient Facilities** | | | | |
| Recommended screenings such as colonoscopy, mammogram, colorectal and bone density scans | No Charge | 40% | No Charge | 50% |
| **Other Services** | | | | |
| **Hospital/Facility Services**[4] | | | | |
| Inpatient care[6]; outpatient surgery[6]<br>Inpatient behavioral health/substance use[2] [5] | 20% | 40% | 30% | 50% |
| Emergency room services[6] | 20% | | 30% | |
| **Maternity** (Global billing for labor and delivery and routine services beyond initial office visit) | 20% | 40% | 30% | 50% |
| **Home Care**[4] (Home health; home infusion therapy) | 20% | 40% | 30% | 50% |
| **Rehabilitation and Therapy Services** | | | | |
| Inpatient and skilled nursing facility[4]; Outpatient PT/ST/OT/ABA; Other therapy | 20% | 40% | 30% | 50% |
| **X-Ray, Lab and Diagnostics** (not including advanced X-rays, scans and imaging) | 20% | 40% | 30% | 50% |
| **Advanced X-Ray, Scans and Imaging**<br>(including MRI, MRA, MRS, CT, CTA, PET and nuclear cardiac imaging studies)[4] | 20% | 40% | 30% | 50% |
| **Pathology and Radiology Reading, Interpretation and Results** | 20% | | 30% | |
| **Ambulance** (medically necessary air and ground) | 20% | | 30% | |
| **Equipment and Supplies**[4] | | | | |
| Durable medical equipment and external prosthetics<br>Other supplies (i.e. ostomy, bandages, dressings) | 20% | 40% | 30% | 50% |
| **Allergy Serum** | 20% | 40% | 30% | 50% |
| **Also Covered** | Certain **dental** benefits, **hospice care** and **out-of-country charges** – See separate sections in this handbook for details | | | |
| **Deductible - ONLY ELIGIBLE EXPENSES COUNT TOWARD THE DEDUCTIBLE** | | | | |
| Employee Only | $1,700 | $3,400 | $2,000 | $4,000 |
| Employee + Child(ren) | $3,400 | $6,800 | $4,000 | $8,000 |
| Employee + Spouse | $3,400 | $6,800 | $4,000 | $8,000 |
| Employee + Spouse +Child(ren) | $3,400 | $6,800 | $4,000 | $8,000 |
| **Out-of-Pocket Maximum - MEDICAL AND PHARMACY COMBINED - ELIGIBLE EXPENSES, INCLUDING DEDUCTIBLE COUNT** | | | | |
| Employee Only | $2,800 | $5,600 | $5,000 | $10,000 |
| Employee + Child(ren) | $5,600 | $11,200 | $10,000 | $20,000 |
| Employee + Spouse | $5,600 | $11,200 | $10,000 | $20,000 |
| Employee + Spouse +Child(ren) | $5,600 | $11,200 | $10,000 | $20,000 |
| **CDHP Health Savings Account (HSA) Contribution** | | | | |
| State contribution made to HSA for individuals enrolled in the CDHP/HSA – State and Higher Education only | $500 for employee only<br>$1,000 for all other coverage levels | | N/A | |

The deductible and out-of-pocket maximum amount can be met by one or more persons but must be met in full before it is considered satisfied for the family. No one family member may contribute more than $8,700 to the in-network family out-of-pocket maximum total.

[1] Subject to maximum allowable charge (MAC). The MAC is the most a plan will pay for a covered service. For non-emergent care from an out-of-network provider who charges more than the MAC, you will pay the copay or coinsurance PLUS the difference between MAC and actual charge, unless otherwise specified by state or federal law.

[2] The following behavioral health services are treated as "inpatient" for the purpose of determining member cost-sharing: residential treatment, partial hospitalization/day treatment programs and intensive outpatient therapy. In addition to services treated as "inpatient" prior authorization (PA) is required for certain outpatient behavioral health services, including but not limited to applied behavioral analysis, transcranial magnetic stimulation, electroconvulsive therapy, psychological testing, and other behavioral health services as determined by the Contractor's clinical staff.

[3] CDHP list of eligible medications and a list of participating Retail-90 pharmacies can be found at https://www.tn.gov/partnersforhealth/health- options/pharmacy.html.

[4] Prior authorization (PA) required, for non-emergent services. When using out-of-network providers, benefits for non-emergent medically necessary services will be reduced by half if PA is required but not obtained, subject to the maximum allowable charge. If services are not medically necessary, no benefits will be provided.

[5] Select Substance Use Treatment Facilities are preferred with an enhanced benefit - members must meet their deductible first, then coinsurance is waived. Deductible/coinsurance for CDHP will apply for standard outpatient treatment services. Call 855-Here4TN for assistance.

[6] In-network benefits apply to certain out-of-network professional services at certain in-network facilities.

# Engaging in Your Health Care

## Blue Distinction Specialty Care®

When you or your family need specialty care, you want the best you can get. Blue Distinction Specialty Care helps you find it. Blue Distinction Centers® and Blue Distinction Centers+® have a proven history of delivering exceptional care and results.

| | Blue Distinction Centers | Blue Distinction Centers+ |
|---|---|---|
| **Quality care** | ✓ | ✓ |
| **Treatment expertise** | ✓ | ✓ |
| **Better overall patient results** | ✓ | ✓ |
| **More affordable care** | | ✓ |

To find out if a Blue Distinction provider is in your network, contact us at **1-800-558-6213**. You can also visit **bcbs.com/blue-distinction-center/facility** for more information.

When viewing the BlueCross BlueShield of Tennessee site, be aware that:

- Bariatric facilities available to you may be different than those listed on the site. Call BlueCross to learn about your bariatric coverage.
- Coverage for family planning services is limited in the State Group Insurance Plan. Check your coverage policy prior to seeking care.

## Quality and Safety in Health Care

Think about the last time you purchased a car or a major appliance. Did you do your homework? Did you compare features, warranties, costs? Now think about the last time you or a family member went to the hospital or had a medical procedure or service. You probably didn't even know you might have a choice, and it's unlikely that you compared services or quality of your health care.

### Quality and safety vary widely in health care.

The resources below can help you and your family find the best place to receive high-quality care. They also offer suggestions about questions to ask your doctor and how to talk with your doctor about choosing what health care you need and which medical tests and treatments you may not need.

- **Know Your Health** — A campaign by ParTNers for Health to educate members on how to engage in their health care and to empower you to become a smarter health care consumer. Includes resources to help you and your family talk with your doctors about choosing the health care you need, what you may not need and the best place to receive care. **tn.gov/partnersforhealth/know-your-health**
- **Leapfrog Hospital Safety Grade** — A consumer-friendly letter grade rating of hospitals on their records of patient safety. Grades are updated twice annually, in the fall and spring. **hospitalsafetygrade.org**

## Tennessee Hospital and Surgery Center Ratings and Safety Grades

- **Compare Hospitals** — Interactive tool that helps you choose the best hospital for you. **leapfroggroup.org/compare-hospitals**
- **Choosing Wisely** — Promoting conversations between patients and clinicians. An initiative of the American Board of Internal Medicine Foundation that seeks to advance a national dialogue on avoiding unnecessary medical tests, treatments and procedures. **choosingwisely.org**

www.hospitalsafetygrade.org

# Covered Medical Expenses

The State, Local Education and Local Government Medical Plan Documents at **www.tn.gov/partnersforhealth/publications/publications.html** contain details about covered medical expenses. Services, treatments, and expenses will be considered covered expenses if:

- They are not listed in the Excluded Services and Procedures section of the Plan Documents and
- They are consistent with plan policies and guidelines; and
- They are determined to be medically necessary and/or clinically necessary by the claims administrator, or
- Coverage is required by applicable state or federal law

**Medical Benefit Reminders**

- **In-network preventive care –** There is no charge to you, but you will be responsible for your share of the cost if your provider bills for something other than preventive care.
- **Emergency Room Services –** Cost sharing for all plan members is deductible and coinsurance. There are no longer any copayments for these benefits. See benefit grids in this handbook for PPO and CDHP cost-sharing amounts.
- **Allergy Serum –** Cost sharing for all plan members is deductible and coinsurance. The benefit for injection of the serum depends on the plan option the member is enrolled in. See benefit grids in this handbook for PPO and CDHP cost-sharing amounts.
- **Physical, Occupational, Speech and ABA Therapies –** PPO members only pay coinsurance for in-network, outpatient physical, occupational, speech and ABA therapies; CDHP/HSA members pay deductible and coinsurance.
- **Cardiac Rehab –** PPO members pay no deductible or coinsurance for in-network, outpatient services; CDHP/HSA members pay deductible, but no coinsurance.
- **If you have scheduled a visit for a colonoscopy or a mammogram,** it is very important that you talk to your health care provider about the type of service you will have. There is no charge for in-network preventive services. However, you will be charged for services scheduled for diagnostic purposes or billed as anything other than preventive care.
- **Ask early if you don't know.** If you are unsure about whether a procedure, type of facility, equipment or any other expense is covered, ask your physician to submit a pre-determination request form to BlueCross describing the condition and planned treatment. Pre-determination requests may take up to three weeks to review.

# Excluded Services and Procedures

The State, Local Education and Local Government Medical Plan Documents at **www.tn.gov/partnersforhealth/publications/publications.html** contain details about excluded expenses. Benefits required by applicable state or federal law or regulations are not excluded. Services, treatments, and expenses will be considered excluded expenses if:

- They are not listed in the Covered Expenses section of the Plan Document; or
- They are inconsistent with plan policies and guidelines; or
- They are determined not to be medically necessary and/or clinically necessary by the claims administrator.

# How the Plan Works

## Choice of Doctors

Your plan doesn't make you choose a primary care provider or get a referral for specialist services. Your network is made up of physicians, hospitals and other health care providers who have contracted with BlueCross to provide discounts for care. You will save money and get the most from your benefits if you use these in-network providers.

While you don´t have to choose a primary care provider, you should get routine care from the same primary-type provider whenever possible.

A primary care provider can be a general practitioner, a doctor who practices family medicine, internal medicine, pediatrics or an OB/GYN. Nurse practitioners, physician assistants and midwives may also be considered primary-type providers when working under the supervision of a primary care provider.

You may sometimes need to see a specialist for a medical condition. Simply choose an in-network specialist and schedule an appointment. If an in-network provider determines you should be admitted to the hospital or need services that require prior authorization, they will handle these plan requirements for you. However, it´s a good idea for you to contact BlueCross to confirm your benefits for hospital admissions or other services that require prior authorization.

If you need help finding and scheduling an appointment with an in-network provider who is accepting new patients or has reasonable availability (i.e., urgent visit in 24 hours, wellness visit in two months, routine medical visit in 14 days, specialist visit in 30 days or routine mental health visit in four days), you can call either BlueCross or Optum.

## Telehealth

**Teladoc Health** makes it easy and convenient to get urgent care and more, all from the comfort of your home. Use it for common issues like fever, sore throat, constipation and skin conditions.

You can quickly make medical appointments, 24 hours a day, seven days a week. It can be easier, less stressful and less expensive than a visit to a primary care provider or urgent care office.

**For PPO plans**, you pay $15 per telehealth visit.
**For CDHP/HSA plans**, you pay the negotiated rate until you reach your deductible, then your primary care office coinsurance applies.

These costs don´t apply to telehealth services you get from a different program or provider.

Learn more and schedule your appointment today. Log in to **bcbst.com** and choose **Talk With a Doctor** to get started.

# Yearly Benefits

The Plan Year begins on January 1 and ends on December 31. Benefits reset each year. This means if your doctor recommends you have a certain service every year, that service will be covered once anytime within the plan year. Services must be considered medically necessary and are subject to any plan limits.

# Maternity Benefits

Coverage for maternity benefits involves an initial office visit cost to verify the pregnancy. Later visits for routine care are covered under what is called "global billing." These charges are included in the cost of labor and delivery. Should complications arise that require additional services of a specialist, additional charges will apply.

# Hospice Benefits

Your plan covers approved hospice programs designed to provide terminally ill patients with more dignified, comfortable and less costly care during the six months before death. Prior authorization is required.

| Plan | Coverage |
|---|---|
| **Premier PPO** | 100% covered |
| **Standard PPO** | 100% covered |
| **Limited PPO** | 100% covered |
| **CDHP/HSA** | 100% covered after deductible |
| **Local CDHP/HSA** | 100% covered after deductible |

# Dental Treatment

Your medical plan covers certain limited benefits for dental treatment — orthodontic treatment for the correction of facial hemiatrophy or congenital birth defect which impairs a bodily function, extraction of impacted wisdom teeth, excision of solid-based oral tumors, eligible expenses for temporomandibular joint malfunction, and accidental injury or damage to sound natural teeth (other than by eating or chewing). Damage means deterioration or loss documented to be the direct result of medically necessary treatment that significantly impairs a covered person's ability to chew and maintain a healthy weight. Charges for the facility and related medical services are also covered when hospitalization for dental services is determined to be medically necessary by the claims administrator.

### Current 2022: Member Costs by Plan:

All benefits are after plan deductible.

| Plan | Oral Surgeons | | Non-Contracted Providers (i.e., dentists, orthodontists) |
|---|---|---|---|
| | In-Network | Out-of-Network | |
| **Premier PPO** | 15% | 40% | 15% |
| **Standard PPO** | 20% | 40% | 20% |
| **Limited PPO** | 30% | 50% | 30% |
| **CDHP/HSA** | 20% | 40% | 20% |
| **Local CDHP/HSA** | 30% | 50% | 30% |

# Transplant Benefits

Prior authorization is required for ALL transplants. Your plan provides cost savings if you have an approved transplant at:

- A BCBS Blue Distinction Center of Excellence; or
- An in-network approved facility if there is no BCBS Blue Distinction COE for the type of transplant you need

If you elect to have covered transplant services at another facility when there is a BCBS Blue Distinction COE option, you will pay the usual member cost share.

Call BlueCross Member Service at **1-800-558-6213** for more information.

| Plan | Cost Savings | Usual In-Network Member Share |
|---|---|---|
| **Premier PPO** | 100% covered | Deductible plus 15% coinsurance |
| **Standard PPO** | 100% covered | Deductible plus 20% coinsurance |
| **Limited PPO** | 100% covered | Deductible plus 30% coinsurance |
| **CDHP/HSA** | 100% covered after deductible | Deductible plus 20% coinsurance |
| **Local CDHP/ HSA** | 100% covered after deductible | Deductible plus 30% coinsurance |

# Benefits: In-Network or Out-of-Network

Check your insurance card to verify whether you have **Blue Network S** or **Blue Network P**. In-network benefits apply when you receive care from doctors and hospitals participating in BlueCross Network S. Receiving in-network care allows the highest level of benefits.

You can receive care from providers who do not participate in Network S, but in most cases, reduced out-of-network benefits will apply. You will also be required to pay the difference between the maximum allowable charge (MAC) and the actual charge.

**Reminder:** Your health care coverage does not allow payment if BlueCross determines a service is not, or was not, medically necessary for your condition.

# Maximum Allowable Charge Defined

The MAC is the maximum amount the plan will pay to a particular provider for a particular service. Providers who have contracted with BlueCross to provide in-network services have agreed to accept that amount as payment in full. This means they write off the rest of the charge after any applicable cost is paid by the member. Out-of-network providers have not agreed to the contracted rate and may balance bill you for the amount above the MAC.

**SEE ALSO:** Sections on emergency care and out-of-network providers at certain in-network facilities.

# Convenient Care and Urgent Care

Members sometimes have a need for medical care during evenings or on weekends. Convenient Care and Urgent Care is care that is important, but does not result from a life-threatening condition. You can search for a provider online or refer to a provider directory to find in-network facilities.

Convenient care clinics can help with common conditions like burns and sprains, sinus infections, sore throats, skin rashes and upset stomachs. These types of clinics are often located in grocery or drug stores. Your cost for a convenient care clinic visit is the same as a primary care visit.

Urgent care centers treat more serious injuries or illnesses, like urinary tract infections, broken bones or deep cuts that may require X-rays or more complicated lab tests. They are often near a hospital but can also be free standing. Your cost for an urgent care center visit is the same as a specialist visit.

# Your Rights and Protections Against Surprise Medical Bills

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care, like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. For more information, see the important notice about surprise medical bills at **https://www.tn.gov/content/dam/tn/finance/fa-benefits/documents/surprise_billing_model_notice.pdf**.

# Emergency Care

If you have a medical emergency, seek treatment at the nearest medical facility. Follow the instructions provided by the emergency room provider for any recommended follow up care. If you require assistance with follow up instructions call your doctor or BlueCross member service.

The emergency room should be used only in the case of an emergency or for urgent care as directed by your doctor. The highest level of benefits is available for any emergency room visit that meets the definition of an emergency explained below. Be sure to ask if the facility is in-network or call us to confirm. You will be responsible for those amounts if it is determined the situation was not an emergency or not medically necessary.

**If you receive a bill for emergency services asking you to pay more than you expected to pay, call BlueCross Member Service. Be prepared to provide a copy of the bill you received, and ask for a review of your claim to see if insurance can pay anything more.**

An emergency medical condition is an illness, injury, symptom (including severe pain) or condition severe enough to risk serious danger to your health if you didn't get medical attention right away.

If you didn't get immediate medical attention you could reasonably expect one of the following:

- Your health would be put in serious danger (or, with respect to pregnant women, the health of the woman or her unborn child)
- You would have serious problems with your bodily functions, or
- You would have serious damage to any part or organ of your body

For each covered emergency room visit, you will pay your portion of the emergency room cost. If you are admitted for more than 23 hours the emergency room visit is considered part of your inpatient services. If the visit is a follow-up visit for the same episode of care within 48 hours of the initial visit to the emergency room, the visit is included in your original emergency room costs. **If you also receive services such as an MRI or CT, you will be charged for those services in addition to your emergency room visit**. Should an out-of-network ER require you to pay in full, file the billing statement along with a claim form with BlueCross and you will be reimbursed subject to the terms and conditions of the plan.

# Out-of-Network Providers at In-Network Facilities

Some providers are not employed by the hospital, ambulatory surgery center or other facility but may provide medical services and care for you. Sometimes these providers are out-of-network, even at an in-network facility. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist or intensivist services.

You are eligible for in-network benefits for covered services received from these providers.

Claims for these types of services may not process to apply in-network benefits the first time. If you receive a bill from one of these out-of-network providers that you saw at an in-network facility, and you are asked to pay more than you expected, call BlueCross Member Service. BlueCross will provide you with assistance to make sure you are not responsible for those amounts. You may be asked to provide a copy of the bill you received from the provider. Also, see the "Your Rights and Protections Against Surprise Medical Bills" section of this handbook.

# Utilization Management

Utilization management programs review requirements and determine authorization for payment of benefits. Programs include:

- Pre-admission certification
- Post-certification of emergency admissions
- Weekend admissions
- Optional second surgical opinions
- Certain outpatient procedures
- Home health
- Case management
- Private duty nursing
- Durable medical equipment
- Provider Administered Specialty Pharmacy program

These programs are used to determine payment of benefits. They are not meant to supersede the physician/patient relationship. The level and duration of medical care is always the patient's decision in conjunction with their physician.

UM decisions are based only on medical appropriateness of care/service and coverage eligibility. The UM organization does not reward practitioners or other individuals for issuing denials of coverage or care.

# Prior Authorization

Prior authorization is designed to encourage the delivery of medically necessary services in the most appropriate setting, consistent with the medical needs of the member and with patterns of care in an established managed care environment for treatment of a particular illness, injury or medical condition.

**PA is required for certain services including some of the more common specific services listed below.** Other specific services are included in broader categories that appear on the list, like inpatient hospital services and specialty medications. Contact BlueCross Member Service before receiving services if you have a question about benefits requiring prior authorization:

- Inpatient hospital services
- Skilled nursing facility stays
- Home health care
- 23-hour observation (when elective, direct admission from MD office and transfer from another facility)
- Hospice
- Home infusion therapy (certain drugs)
- Private duty nursing
- Advanced X-rays, scans and imaging
- Durable medical equipment (certain equipment greater than $500)
- Chemotherapy and radiation therapies
- Provider-administered specialty medications (administered in provider offices, inpatient and outpatient hospitals, infusion centers, home health, etc. and not at a pharmacy)
- Non-emergent ambulance transport (air and ground)
- Certain musculoskeletal procedures (including, but not limited to, spinal surgeries, spinal injections and hip, knee and shoulder surgeries)
- Neonatal ICU
- Advanced therapeutics used to treat or cure genetic conditions
- Bariatric
- Transplants
- Genetic testing – certain outpatient genomic and molecular testing
- Hysterectomy
- Endometrial ablation
- Varicose veins
- Blepharoplasty/browplasty
- Breast surgery for augmentation or reduction
- Hyperbaric treatments
- Panniculectomy
- Hearing aids

All providers for the above services should request these authorizations prior to delivering services. If an in-network provider does not obtain required authorization, no benefits will be paid, and both the plan and the covered person shall be held harmless.

Out-of-network providers are not contracted. If you receive medically or clinically necessary care from an out-of-network provider, you are responsible for verifying with BlueCross that required prior authorizations have been requested and approved before receiving care.

When PA is required but not obtained, benefits for medically necessary services received out of network will be reduced by half, subject to the maximum allowable charge.

**PA is not required for maternity admissions or emergency care.**

BlueCross does not manage PA for pharmacy benefits or behavioral health and substance use treatment. Contact information for those programs is provided under the "Important Contact Information" section of this handbook.

## Hospitalization

If you need to be hospitalized, your doctor should make the necessary arrangements at an in-network facility. Be sure to ask if the facility is in-network or call us to confirm. Your doctor should also coordinate your care and prior authorization with BlueCross. If you are admitted to a hospital (in-network or out-of-network) without prior authorization, your benefits will be greatly reduced.

If you are out of the network service area or for some reason are unable to reach your doctor before seeking care, you should follow the discharge instructions for follow up care. If you require assistance with obtaining recommended follow up care, contact your doctor or BlueCross member services.

## Advanced Radiological Imaging

PA is required for certain non-routine diagnostic services and the setting for such services. BlueCross will coordinate review for medical appropriateness and necessity before the services are performed. Services subject to such review include magnetic resonance imaging, magnetic resonance angiography, magnetic resonance spectroscopy, computerized tomography, computerized tomography angiography, positron emission tomography scans and nuclear cardiac imaging studies.

## Durable Medical Equipment

The plan covers certain durable medical equipment determined to be medically necessary on the basis of an individual's medical and physical condition.

Some equipment requires prior authorization. Generally, PA only applies to more expensive items. Providers should request PA, if needed, before providing equipment to you. You can also contact BlueCross to see if the equipment you need requires PA and if any necessary PA has been approved.

Depending on the type of equipment needed, DME may be furnished on a rental basis or purchased. Types of equipment include blood glucose monitors and breathing equipment such as oxygen tanks, tents, regulators and flow meters. DME is not for comfort or convenience. Items are typically prescribed by a physician when recognized as therapeutic for a patient's diagnosis.

## Coordination of Benefits with Other Insurance Plans

Once a year, you will be asked to validate the information on file concerning other coverage. This is done because it is not uncommon for this type of information to change. Periodic validation helps us ensure accurate claims payments.

BlueCross will send each member a reminder letter once per year and it is the responsibility of the member to update their other insurance or claims will stop processing. Members can do this by logging in to their **bcbst.com** account and clicking **Other Insurance** in the **Benefits & Coverage** dropdown menu.

**REMEMBER:** Members MUST update their other insurance coverage even if they do NOT have other coverage.

If you are covered under two different insurance plans, benefits will be coordinated for reimbursement up to 100% of allowable charges. At no time should reimbursement be more than 100% of actual expenses.

COB will be applied to your claims so that:

- If you have other primary medical coverage, and secondary medical coverage with this plan, you will pay any cost share required by this plan.
- If you have primary and secondary coverage with this plan, you will pay the cost share required by this plan's secondary coverage.

If you are covered as the subscriber or employee by more than one group health program, primary and secondary liability between the plans will be determined based on the order of benefit determination rules included in the Plan Document.

Different coordination of benefit rules apply based on the type(s) of policies you may have and the status of those policies (e.g. active, retired, COBRA).

If your spouse has coverage through their employer and has you covered, that coverage would be primary for your spouse and secondary for you. When this medical plan is primary, the benefits of this plan are calculated just as if the other plan did not provide benefits.

Primary coverage on children is determined by which parent's birthday comes earliest in the calendar year. The insurance of the parent whose birthday falls last will be considered the secondary plan. The determination of primary or secondary coverage may be altered in the case of divorced parents when a court decree specifically designates the parent whose coverage will be primary. A copy of the court decree should be submitted to BlueCross.

If none of the above rules determines the order of benefits, the benefits of the plan that has covered an employee, member or subscriber longer are determined before those of the plan which has covered that person for the shorter time.
For example, if a married dependent child under the age of 26 is covered by a parent under this plan and also has coverage under their spouse's plan, the primary plan will be the plan which has covered the dependent child for the longer period of time.

# Claims Subrogation

The medical plan has the right to subrogate claims. This means the medical plan can recover (1) any payments made as a result of injury or illness caused by the action or fault of another person, or (2) a lawsuit settlement from payments made by a third party or insurer of a third-party. This would include automobile or homeowners insurance, whether yours or another's.

You are required to assist in this process and should not settle any claim without written consent from the BlueCross subrogation department. Failure to respond to the plan's requests for information, and to reimburse the plan for any money received for medical expenses, may result in the covered person's disenrollment from the plan. Such disenrollment shall extend to any dependents who obtained coverage through the covered person.

# Benefit Level Exceptions

Three types of exceptions – Unique Care, Transition of Care and Continuity of Care — may be granted. These exceptions allow benefits to be paid at the in-network level to an out-of-network provider or facility. **Any charges above the maximum allowable charge are the patient's responsibility.** All requests for exceptions are reviewed by BlueCross. Exceptions will be granted only for medical necessity, not for convenience. To apply for an exception, work with your provider to submit the following information in a letter to BlueCross BlueShield, Attention State Unique Care Coordinator. Within two to three weeks, you will be notified whether your request is granted or denied. If the items listed below are not provided with the initial request, the decision may be delayed until all information can be gathered.

- Patient name and ID number
- Name and type of provider you are requesting
- Diagnosis and treatment plan, date(s) of service
- A statement explaining why this treatment cannot be received at an in-network facility or provided by an in-network physician

# Unique Care

A unique care exception can be granted for treatment not routinely available from an in-network provider in a member's geographic area. This exception is based on the patient's condition or need for a particular physician and must be requested before receiving care. We will determine whether an in-network provider is available to provide treatment for the illness or injury.

If a unique care exception is granted, benefits are paid at the in-network level. If out-of-state traveling is required, reimbursement will be at 80% of commercial coach airfare or ground travel at the state-approved mileage rate or for actual fuel expenses.

When unique care exceptions are granted, a time frame for this approval is given. If more time for unique care is needed beyond the stated time frame, then another unique care request must be submitted before the time frame is exceeded. Updated medical information documenting the continued need for out-of-network care will be required.

The review of this unique care approval extension request will include a review of the available network to determine if the required care can now be accessed within the network.

# Transition of Care

With Transition of Care, you may be able to continue to receive services for specified medical conditions with health care providers who are not in the BCBS network at in-network coverage levels. This care is for a defined period of time until the safe transfer of care to an in-network provider or facility can be arranged. You must apply for Transition of Care at enrollment, or when there is a change in your medical plan. You must apply no later than 30 days after the effective date of your coverage. To apply, complete the **Medical Transition of Care request form** found on the BCBS member web page, or call BCBS for assistance.

# Continuity of Care

With Continuity of Care, you can receive services at in-network coverage levels for specified medical conditions when your health care provider leaves your plan's network and the immediate transfer of your care to another health care provider would be inappropriate and/or unsafe. This care is for a defined period of time. You must apply for Continuity of Care within 30 days of your health care provider's termination date. This is the date that they are leaving your plan's network. To apply, complete the **Medical Transition of Care request form** found on the BCBS member web page, or call BCBS for assistance.

# Coverage for Second Surgical Opinion Charges

In some instances, you have the option to receive a second surgical opinion. Second surgical opinions are not required. The second surgical opinion must be obtained from a surgeon qualified to perform the surgical procedure, but who is not in the same medical group as the physician who originally recommended surgery.

**For PPO plan members**, charges for the second surgical opinion and any tests performed in obtaining the second surgical opinion will be paid at 100% of the maximum allowable charge, if an in-network provider is used. **CDHP plan members** must first meet the annual deductible requirement.

The payment in full provision does not apply to the CDHP health care options unless annual deductible requirements have already been met.

If you wish to obtain a second surgical opinion about a procedure not included on the list below, normal plan benefits and rules apply. Any surgeries (including those listed) must be medically necessary to be approved.

- Bone and joint surgery of the foot
- Cataract extraction with and without implant
- Cholecystectomy
- Hysterectomy
- Knee surgery
- Septoplasty/sub-mucous resection
- Prostatectomy
- Spinal and disc surgery
- Tonsillectomy and adenoidectomy
- Mastectomy
- Elective C-section

# Expert Medical Opinion

If you're facing a serious medical condition or considering different treatment options, getting a second opinion can help you feel more confident about your care and result in better health outcomes.

ConsumerMedical can help you get a virtual second opinion from top specialists for your condition or treatment.

When you should consider a second opinion:

- For help confirming a diagnosis
- For assistance with a rare or life-threatening condition
- For a risky, controversial or experimental treatment
- To understand why you did not respond as expected to a treatment

Register for ConsumerMedical online at **myconsumermedical.com** with the company code **BCBST State of TN**.

You can also call **1-888-361-3944** Monday through Friday from 8:30 a.m. to 11 p.m. ET.

# Case Management

Case management is a program that promotes quality and cost-effective coordination of care for members with complicated medical needs, chronic illnesses and/or catastrophic illnesses or injuries. Members who need case management are identified and contacted by phone or in writing regarding alternative treatment plans. Members or providers may also contact member services if they believe they would benefit from case management.

# Filing Claims

BlueCross is responsible for all medical plan claims processing. When you visit an in-network doctor or facility, be sure to show your identification card.

The provider will file your claim directly. These in-network providers must file your claim within six months of the date of service. All questions regarding claims, including requests for claim forms, should be addressed to member services.

If you visit an out-of-network doctor or facility, you may be responsible for filing claims yourself. Out-of-network providers may also require payment in full at the time of service. The correct form must be used and a separate claim form must be completed for each individual who received services. More than one bill can be submitted on a claim form. The member claim form can be found at **bcbst.com/tn_state**, in the **Resources** section under **Forms**. For out-of-network providers, you have 13 months from the date of service to file claims and be eligible for reimbursement.

BlueCross is not responsible for processing claims for pharmacy or behavioral health and substance use treatment. Contact information for those programs is provided under the "Important Contact Information" section of this handbook.

# Out-of-State Providers

Members who live outside of Tennessee still have access to in-network providers through our national network. Use the following steps to search for an out-of-state provider. Log in to your account at **bcbst.com/tn_state**. Click on **Find Care & Estimate Costs**. Choose your network and enter your location. Then search or browse providers by category.

You can also contact BlueCross at the toll-free member service number on your ID card. We will be happy to assist you with locating a network provider in your area.

# Out-of-Country Care

When traveling outside of the United States for business or pleasure, eligible expenses for medically necessary emergency and urgent care services are covered at the in-network level. Other medically necessary care will be covered at the out- of-network level. No benefits will be paid if a covered person travels to another country for the purpose of seeking medical treatment outside the United States. Claims from a non-English speaking country should be translated to standard English at the covered person's expense.

Claim forms should contain valid procedure and diagnosis codes and include the current exchange rate, if available, before being submitted for payment.

When you need health care outside the U.S., follow these simple steps:

1. Always carry your BlueCross BlueShield of Tennessee identification card.
2. Check with member services at **1-800-558-6213** before leaving the U.S.
3. If you need emergency medical care, go to the nearest hospital. Call the BlueCross BlueShield Global Core℠ Service Center at **1-800-810 BLUE (2583)** or call collect at **(804) 673-1177** if you are admitted.
4. If you need non-emergency medical care, you must call the BlueCross BlueShield Global Core Service Center. The Service Center will facilitate hospitalization at a BlueCross BlueShield Global Core hospital or make an appointment with a doctor. It is important that you call the BlueCross BlueShield Global Core Service Center in order to get cashless access for inpatient care. The service center is staffed with multilingual representatives and is available 24 hours a day, seven days a week.

**Out-of-Country Benefits**
non-emergency and non-urgent care

Out-of-Network benefits only;
Out-of-Network deductible applies

| Plan | Coinsurance |
|---|---|
| **Premier PPO** | 40% |
| **Standard PPO** | 40% |
| **Limited PPO** | 50% |
| **CDHP/HSA** | 40% |
| **Local CDHP/HSA** | 50% |

# Member Discount Program

We want to make it easier for you to live a healthy lifestyle with our member discount program. You can save on a wide range of health and wellness-related products and services. To see your discounts, log in to your account at **bcbst.com/tn_state**. Then, click **Managing Your Health** and select **Member Discounts & Fitness Your Way**. You can also find information about your discounts using the **BCBSTN** app.

You can save on:

- Apparel & footwear
- Fitness
- Hearing & vision
- Home & family
- Nutrition
- Personal care
- Travel

Check often for new offers, or get offers sent to your inbox.

# Pharmacy Benefits

Pharmacy benefits are administered by CVS Caremark and not BlueCross BlueShield of Tennessee. Please call **1-877-522-8679** for further information or visit **info.caremark.com/stateoftn**. Once there, you can view the State of Tennessee Group Insurance Program Prescription Drug List, Specialty Drug List, Vaccine Network Pharmacy List, Medications Requiring Prior Authorization for Medical Necessity, and the Retail-90 Network Pharmacy List. Any medication classified as a specialty medication can only be filled for a 30-day supply and must be filled through a pharmacy in the CVS Caremark Specialty Network.

Three levels of benefits are available for prescription drugs, and your choice determines the amount you pay each time you have your drugs dispensed by a pharmacy.

- **Generic drugs** are in the first tier and offer the best value. When your doctor writes your prescription, ask about using a generic drug. Generics are safe, effective and affordable alternatives to brand name drugs and are available in many instances.
- **Preferred brands** are in the second tier. If a generic alternative is not available, talk to your doctor about prescribing a brand-name drug from the preferred drug list. This list includes many popular brand-name drugs.

› **Non-preferred brands** are in the third tier and will cost you more.

When a generic is available and the member's physician has indicated "may substitute" but the pharmacy dispenses the brand name **based on the member's request**, the member will pay the difference between the brand name drug and the generic drug **plus** the brand copay or coinsurance.

## Specialty Drugs

Certain chronic or genetic conditions require specialty pharmacy products, typically in the form of injected or infused medications. Specialty drugs are limited to a 30-day supply and must be filled through a pharmacy in the CVS Caremark Specialty Network. A specialty pharmacy drug list is available at **info.caremark.com/stateoftn** > **Drug Lists** > **Specialty Drug List**.

**PPO plan members** will pay a different coinsurance percentage for specialty drugs, depending on whether the drug is Tier 1 (generics) or Tier 2 (all brands).

**CDHP plan members** must first pay their deductible and then coinsurance for specialty drugs (regardless of whether the drug is generic or brand name). See the Benefit Grids in this handbook for member cost.

## Medication-Assisted Treatment

Medication assisted treatment combines behavioral therapy and medications to treat substance use disorders. Members do not have to pay for specific medications used to treat opioid dependency.

## Maintenance Medications

When you fill a prescription for certain chronic maintenance medications, you can save money by paying a lower copay or coinsurance when you have your doctor write a prescription for a 90-day supply and you fill it through mail order or from a participating Retail-90 pharmacy. A CDHP list of eligible medications, a PPO list of eligible medication classes and a list of participating Retail-90 pharmacies can be found at **https://www.tn.gov/partnersforhealth/health-options/pharmacy.html**.

## Med Sync for Maintenance Medications

You can request that refills of your maintenance medications be synchronized so you can have them all filled on the same day. If you're enrolled in a PPO, you will pay pro-rated copays for any maintenance drugs being synchronized. Those enrolled in a CDHP will pay the plan discounted drug cost. If you want to sync your maintenance drugs, you will need to work with your retail pharmacy or mail order pharmacy to coordinate synchronization of your refills.

## Compound Drugs

Any and all compound drugs (as determined by the pharmacy benefits manager) must be processed electronically. Paper claims will not be reimbursed and will be denied. In addition, many compound drugs require prior authorization by the pharmacy benefits manager before claims processing and determination on payment will occur.

## Statin Drugs

Eligible members may receive certain low-dose statins in-network at zero cost share. These drugs are primarily used to treat high cholesterol. No high dose or brand statins are included.

## Weight Management

Some obesity medications are available for members who meet certain requirements. This gives members a less costly, non-surgical option for losing weight. Go to the Caremark website at **info.caremark.com/stateoftn** to look for covered medications. They are found under "Antiobesity" on the State of Tennessee Preferred Drug List with Advanced Control Specialty Formulary.

# Tobacco Cessation Products

Members who want to stop using tobacco products can get free tobacco quit aids. Varenicline (Generic Chantix), Bupropion (Generic Zyban), over-the-counter generic nicotine replacement products (including gum, patches and lozenges) and Nicotrol oral and nasal inhalers are FREE under the pharmacy benefit. Members may get up to two, 12-week courses of treatment per calendar year (up to 168 days of treatment) with no lifetime maximum. A licensed clinician is required to write a prescription to get any tobacco cessation products at no cost, including over-the-counter aids. Simply present your prescription and your Caremark card at the pharmacy counter (not at the check-out registers) to fill at $0 copay. The plan only covers generic over-the-counter tobacco cessation products, not brand names.

# Copay Installment Program

Members can spread the cost of 90-day mail order prescriptions over a three-month period at no additional cost. You may enroll online at **info.caremark.com/stateoftn**, by registering and logging in, or by calling CVS Caremark customer care at **1-877-522-8679**. This benefit is only for 90-day mail order prescriptions provided by CVS Caremark mail order. This does not apply to specialty medications.

# Flu and Pneumonia Vaccines

Each year, members can get free flu and pneumonia vaccines (if eligible) through certain pharmacies or at a participating doctor's office. Contact CVS Caremark (pharmacy benefits) or BlueCross (medical benefits) for more information or go to **tn.gov/partnersforhealth** and click on **Health Options/Pharmacy**.

# Behavioral Health, Substance Use and Employee Assistance Program – Here4TN

You and your dependents enrolled in health coverage are eligible for behavioral health and substance use benefits, which are administered by Optum Behavioral Health.

Optum can be reached toll-free at **1-855-Here4TN (1-855-437-3486)** any time, day or night, to speak confidentially with a trained professional for a referral.

Services generally include the following:

- Outpatient assessment and treatment
- Virtual visits — visits with a provider through private, secure video conferencing
- Inpatient assessment and treatment
- Enhanced benefit for facility-based substance use treatment at select facilities — call **1-855-Here4TN** for assistance
- Partial hospitalization
- Residential treatment
- Intensive outpatient treatment
- Treatment follow-up and aftercare

Certain services are specifically excluded under the terms and conditions of the State Group Insurance Program. For more information, contact Optum.

To receive maximum benefit coverage, participants must use an in-network provider and obtain prior authorization for inpatient services as well as some outpatient services including psychological testing, electro-convulsive treatment, applied behavior analysis and transcranial magnetic stimulation.

Out-of-network behavioral health benefits are available; however, your cost will be higher. You are also subject to balance billing by the out-of-network provider, meaning you will pay the difference between the maximum allowable charge and the actual charge. You are also at risk of having inpatient benefits denied.

You also have access to an Employee Assistance Program, or EAP. EAP counseling sessions are issued and authorized on a per-problem-per-year-per-person basis. For example, the member receives five counseling sessions for each problem. Should a different unrelated problem arise within the same plan year, the member would receive an additional five sessions to address the new problem. A different problem is either: 1) a new issue for which the member has received no previous counseling, or 2) an existing issue that has not been treated in that plan year. Examples of different problems (not an exhaustive list): relationship issues, job stress, parenting issues, caregiving of a loved one and death of a loved one. EAP counseling is now available through virtual visits as well. Go to **Here4TN.com** for more information.

In addition to counseling support, your EAP provides a variety of consulting services, including financial, legal, childcare and eldercare.

Prior authorization is required to see an EAP provider and can be obtained by either logging in to **Here4TN.com** or calling **1-855-Here4TN (1-855-437-3486)**. The website provides valuable health information, tools and resources to help with life's challenges as well as opportunities. This site offers you the ability to take self-assessment tests, online trainings, search for providers, access a map of your provider's location and get driving directions. You may set up your own unique account number and password for confidential and anonymous access to a wide variety of information and resources. This includes viewing claims information online.

Optum also has its own policies and procedures to protect your privacy. These policies guide Optum staff, providers and visitors on how to keep information private. By signing Optum's Authorization to Use or Disclose Protected Health Information Form, you permit Optum to disclose your personal information. If you have a guardian or someone selected by the court, they can sign the form for you. Optum can only give your information to you or the designated person. To get the form, please call **1-855-437-3486**.

## ParTNers for Health Wellness Program

**Resources:**

- **Sanvello**, an on-demand mobile app to help with stress, anxiety and depression
- **Talkspace**, online therapy including text, audio and video within a secure app.

Learn more at **Here4TN.com**

The ParTNers for Health Wellness Program is voluntary and members are not required to complete any wellness program activities. ActiveHealth Management, the wellness vendor, will send more information directly to members about the programs, tools and resources that are available in 2023.

Go to **go.activehealth.com/wellnesstn** for updates.

- State and higher education members and enrolled spouses can earn money by completing certain wellness activities. The money will be deposited into the head of contract's paycheck. Members choose activities from an approved list. Each activity will have a dollar value, and you can earn up to $250 each. That is $500 for the employee and spouse.
- Local education and local government employees, retirees, COBRA participants and enrolled spouses will have access to a health assessment, coaching support (online personal or group coaching, or by phone) for disease management programs such as asthma, diabetes, congestive heart failure, coronary artery disease and chronic obstructive pulmonary disease. You will get emails about coaching support that's available to you. It is completely voluntary and won't cost you anything. In addition you will have access to the web portal and mobile app where you can get access to your coaches, the health assessment and tips and trackers.
- There is also a Diabetes Prevention Program (DPP) for those with prediabetes who qualify for the program. BlueCross is partnering with Livongo to offer an online DPP. It is FREE to eligible members and their dependents age 18 and older to help manage your weight and reduce your risk of developing type 2 diabetes. log in to your account. If you have questions, call **1-888-599-7483**. Be sure to have your BlueCross Member ID with you when you call.

# Member Rights and Responsibilities

## Member Rights

You have the right to:

- Be treated with respect and dignity.
- Expect that any information you give will be treated in a confidential manner.
- Information about policies and services of the plan.
- Information regarding in-network providers.
- Medically necessary and appropriate medical care.
- Information about your health.
- Make decisions about your health care with practitioners.
- Voice complaints about your health care providers, the care given to you or the plan. You can expect an answer within a reasonable time. You also have the right to formally appeal answers if you do not agree.
- A candid discussion of appropriate or medically necessary care options for your condition, regardless of cost or benefit coverage.

# Confidentiality and Privacy

Your health is your own private business. Be assured that we will treat your medical records and claims payment history in a confidential manner. When you enroll in the plan, you give routine consent for certain matters. That allows the company to release information without your prior written consent for these purposes:

- Claim processing.
- Performing peer review, utilization review and medical audits.
- Administration of programs established by us for quality health care and control of health care costs.
- Medical research and education.

Important steps are taken to protect your privacy.

- Employees have been trained to understand the importance of safeguarding your privacy. In fact, they sign confidentiality agreements to ensure they will carry out the established policies.
- Contracted practitioners and providers follow confidentiality guidelines set forth by the state in which they practice.
- Vendors must sign confidentiality agreements if they receive personal health information for purposes of plan administration such as measurement of data to improve quality.
- It is our policy not to release member-specific health information to employers unless allowed by law.
- Members have the right to approve the release of personal health information in special circumstances beyond those listed above.

Members can take comfort in knowing that confidentiality is important to us. You are encouraged to call BlueCross if you have questions about privacy policies and practices.

# Women's Health and Cancer Rights Act

Your medical plan's coverage of a medically necessary mastectomy also includes post-mastectomy coverage for reconstruction of the breast, surgery on the other breast to achieve the appearance of symmetry, prostheses and physical complications during any stage of the mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and patient.

Benefits are subject to the same cost sharing as other services.

# Member Responsibilities

Members are responsible for:

- Reading the member materials in their entirety and complying with the rules and limitations as stated.
- Contacting in-network providers to arrange for medical appointments as necessary.
- Notifying providers in a timely manner of any cancellations of appointments.
- Paying the cost sharing as stated in the benefit plan documents at the time service is provided.
- Receiving prior authorization for services when required, and complying with the limits of the prior authorization.
- Carrying and using their plan identification card and identifying themselves as a plan member prior to receiving medical services.
- Using in-network providers consistent with the applicable benefit plan.
- Providing, to the extent possible, information needed by professional staff in order to care for the member.
- Following instructions and guidelines given by those providing health care services.

# Appeals

Information in this section does not apply to any complaint alleging possible professional liability, commonly known as malpractice, or for any complaint concerning benefits provided by any other plan. In the event of a conflict between information in this handbook and applicable state or federal law, the applicable law shall control.

The appeals process follows federal rules and regulations and assigns appeal responsibilities to the carriers and independent review organizations. **For more information** see the State, Local Education or Local Government Plan Documents at **tn.gov/partnersforhealth**. Look under the Publications tab and Medical Plan Documents.

**You may submit any appeals described in the sections that follow with or without the help of an authorized person or personal representative.**

The plan does not provide an appeal process for providers, does not review disputes under a provider contract with a claims administrator and does not permit covered persons to assign appeal rights to a provider. A provider may help you prepare an appeal but shall not become a party to the appeal. Providers may appeal to claims administrators on their own behalf if permitted by an agreement between the provider and the claims administrator or state or federal law. Such appeals are outside of appeal or administrative remedies provided under this plan.

## Call First

You can call with or without help from an authorized person or personal representative. A telephone call does not constitute an appeal, but a call should be made as soon as possible upon learning of any enrollment or premium issue or denial of payment or medical services. **Call as soon as possible for faster resolution and to avoid missing deadlines.**

**Enrollment or Premium Issues –** Call Benefits Administration at **1-800-253-9981** or visit **tn.gov/partnersforhealth**.

**Medical Services or Payment Issues** — call the telephone number listed on your insurance card. The separate phone numbers for behavioral health and substance use, pharmacy and medical can also be found at the front of this handbook under **"Important Contact Information" on page 8.**

## Deadline to File Appeals

If an issue is not resolved and you want to start an appeal, **you have 180 calendar days** after you receive notice of an adverse determination.

## Enrollment and Premium Appeals

Contact Benefits Administration at Benefits.Administration@tn.gov, or write to:

State of Tennessee, Department of Finance and Administration, Benefits Administration
312 Rosa L. Parks Avenue, Suite 1900
William R. Snodgrass Tennessee Tower
Nashville, TN 37243-1102

- Enrollment and premium appeals are submitted to and decided by the Benefits Administration Review Team
- No external administrative appeal is provided
- An enrollment appeal cannot be utilized to make mid-year benefit election changes not otherwise permitted by the plan
- A retroactive termination of enrollment that meets the definition of "rescission" under 45 CFR147.128 is appealable and shall be resolved in accordance with federal law

## Behavioral Health and Substance Use Appeals

Contact Optum at **1-855-437-3486** for EAP, behavioral health and substance use appeals or write to:

Optum Appeals and Grievances
P.O. Box 30512
Salt Lake City, UT 84130-0512
Fax: 855-312-1470

## Pharmacy Appeals

Contact CVS Caremark at **1-877-522-8679** for pharmacy appeals or write to:

CVS Caremark Appeals Department MC109
P.O. Box 52084
Phoenix, AZ 85072-2084

Please include: your name and member ID number, doctor's name and telephone number, name of medication and information relevant to your appeal.

# Medical Service Appeals

If you disagree with a coverage decision or the way a claim has been paid or processed, you should **first call BCBST member service at 1-800-558-6213** to discuss the issue.

**First Internal Appeal** — If the issue cannot be resolved through member services, you may file an appeal/member grievance.

**You will have 180 days to start an internal appeal with BlueCross BlueShield following notice of an adverse determination**. The appeal/grievance form can be found on the BlueCross BlueShield of Tennessee Member **Resources** page under **Forms** at **bcbst.com/members/tn_state**. Once a determination is made, you will be notified in writing and advised of any further appeal options and timeframes for filing additional appeals. All requests must be filed within the specified timeframes.

**Second Internal Appeal** — In addition to the initial internal appeal, you may initiate a second internal appeal within 180 calendar days from receipt of an adverse determination of the initial appeal.

**External Review** — When an appeal decision made by BlueCross BlueShield is unfavorable and the appeal qualifies for external review, BlueCross BlueShield will advise you of the right to initiate an external appeal. External appeals are considered by an Independent Review Organization.

If you choose to pursue an external appeal, you must submit a request within four months of the notice of the appeal decision you receive from BlueCross BlueShield.

**Expedited Reconsideration** — If a denial of coverage or authorization can reasonably be expected to prevent a covered individual from obtaining urgently needed covered services (e.g., emergency or life-threatening procedures), then you may request an expedited reconsideration. If the treating provider fails to request the reconsideration and decides not to provide urgently needed services, then you, or your authorized representative, may request the expedited reconsideration. If BlueCross BlueShield agrees it is appropriate to conduct an expedited reconsideration, they will inform you of their decision as quickly as possible based on the circumstances of the care, including the ability to obtain information concerning the case from the provider.

**Please Note:** The expedited reconsideration process only applies in situations where a benefit determination or a prior authorization denial has been made prior to services being received.

Notification of decisions will be made within the following time frames and all decision notices shall advise of any further appeal options:

- No later than 72 hours after the receipt of the appeal for urgently needed services
- 30 days after receipt of the appeal for denials of non-urgent care not yet received
- 60 days after receipt of the appeal for denials of services already received

# Q&A

**Q Is my child who is attending college out of state covered at the network level?**

A Children attending an out-of-state college can still see nearby in-network providers. Help your child find a provider by logging in to your account at **bcbst.com/tn_state**. Click on **Find Care & Estimate Costs**. Choose your network and enter your child´s location. Then search or browse providers by category.

**Q Other than the benefit level, are there other differences if I use out-of-network providers?**

A Out-of-network providers can bill you for any difference between actual charges and the maximum allowable charge plus any services deemed not medically necessary or not authorized. When you use an out-of-network provider, the charges for which you are responsible may be substantial.

**Q What happens if my doctor disagrees with a medical policy regarding my covered treatment alternatives?**

A A provider appeals process is available for this situation.

**Q Do I have a choice of hospitals?**

A We have contracted with certain hospitals to provide in-network care to you. If specialty care is not available at the contracted in-network hospital(s), arrangements may be made with the appropriate out-of-network hospital. You can request a unique care exception as outlined on page 26.

**Q I received a bill from an out-of-network provider that I wasn't expecting. What can I do?**

A Call BlueCross. We will review your claim and explanation of benefits with you to determine and explain your cost share. You may be asked to provide a copy of the bill from the provider. In some cases you may not be responsible for expenses which exceed the maximum allowable charge. See page 22 for more information on emergency care and out-of-network providers at in-network facilities.

**Q What if I must reach my physician after regular office hours or if my doctor is out of the office?**

A Doctors "cover" for each other on a rotating schedule. This means you may not always be able to talk with your doctor. Most offices have an answering service. When you call after regular office hours, you will most likely talk to a representative from the answering service. The on-call nurse or doctor will be able to help you. They may ask for some identifying information and will need a general description of your urgent medical need.

Another option is telehealth through Teladoc Health, which allows you to receive care through virtual visits. You can contact a doctor for minor illnesses such as cold or flu, infections, fever and more. Schedule a visit for you or your covered dependents for anywhere, at any time. **For PPO plans**, the cost is only $15 per telehealth visit. **For CDHP plans**, you pay the negotiated rate until you reach your deductible, then the primary care office visit coinsurance applies.

Pre-registration is very important so you can access Teladoc Health services when you need them.

Call member services if you have any questions or need help with the registration process.

**Q How do I receive services covered by the Barry Brady Act?**

A If you are a firefighter who qualifies for additional health screenings under the Barry Brady Act and your related claims process with unexpected member cost share, call BlueCross Member service and request a reconsideration of your claims.

BlueCross BlueShield of Tennessee (BlueCross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BlueCross does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

BlueCross:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified interpreters and (2) written information in other formats, such as large print, audio and accessible electronic formats.
- Provides free language services to people whose primary language is not English, such as: (1) qualified interpreters and (2) written information in other languages.

If you need these services, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711).

If you believe that BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance ("Nondiscrimination Grievance"). For help with preparing and submitting your Nondiscrimination Grievance, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711). They can provide you with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address your Nondiscrimination Grievance to: Nondiscrimination Compliance Coordinator; c/o Manager, Operations, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; (423) 591-9208 (fax); Nondiscrimination_OfficeGM@bcbst.com (email).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–368–1019, 800–537–7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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BlueCross BlueShield of Tennessee is a Qualified Health Plan Issuer in the Health Insurance Marketplace.

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ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Si usted es miembro, llame al número de Servicio de atención a miembros que figura al reverso de su tarjeta de identificación de Miembro o al 1-800-565-9140 (TTY: 1-800-848-0298).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بلامجان.
إذا كنت عضوًا، فاتصل برقم خدمة الأعضاء الموجود على ظهر بطاقة هوية العضو أو بالرقم 1-800-565-9140 (الهاتف النصي: 1-800-848-0298).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。
若您是會員，請撥打會員 ID 卡背面的會員服務部號碼或 1-800-565-9140（聽障專線 (TTY)：1-800-848-0298）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
Nếu quý vị là hội viên, hãy gọi đến số Dịch vụ Hội viên ở mặt sau thẻ ID Hội viên của quý vị hoặc 1-800-565-9140 (TTY: 1-800-848-0298).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
가입자의 경우, 가입자 ID 카드 뒷면의 가입자 서비스 전화번호 또는 1-800-565-9140(TTY: 1-800-848-0298) 번으로 전화하시기 바랍니다.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.
Si vous êtes adhérent, appelez le numéro du Service adhérents indiqué au dos de votre carte d'assuré adhérent ou appelez le 1-800-565-9140 (TTY/ATS : 1-800-848-0298).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ,ການບໍລິການຊ່ວຍເຫຼືອດ້ ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ.
ຖ້າທ່ານເປັນສະມາຊິກ, ໃຫ້ໂທຫາເບີຂອງຝ່າຍບໍລິການສະມາຊິກທີ່ມີຢູ່ດ້ານຫຼັງບັດ ID ສະມາຊິກຂອງທ່ານ ຫຼື 1-800-565-9140 (TTY: 1-800-848-0298).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡
አባል ከሆኑ፣ በአባልነት መታወቂያዎ ጀርባ ላይ በሚገኘው የአባላት አገልግሎት ቁጥር ወይም በ 1-800-565-9140 (መስማት ለተሳናቸው፣ TTY: 1-800-848-0298) ይደውሉ።

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Falls Sie ein Mitglied sind, rufen Sie die Nummer des Mitgliederdienstes auf der Rückseite Ihrer Mitglieds-ID-Karte oder 1-800-565-9140 (TTY: 1-800-848-0298) an.

સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે.
જો તમે સભ્ય છો, તો તમારા સભ્ય આઈડી કાર્ડની પાછળના સભ્ય સર્વિસ નંબર ઉપર અથવા 1-800-565-9140 (TTY: 1-800-848-0298) પર કૉલ કરો.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
会員のお客様は、会員IDカードの裏面に記載の会員サービス番号あるいは1-800-565-9140 (TTY: 1-800-848-0298)まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Kung ikaw ay isang miyembro, tawagan ang numero ng Serbisyo sa Miyembro na nasa likod ng iyong Kard ng ID ng Miyembro o sa 1-800-565-9140 (TTY: 1-800-848-0298).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।
अगर आप सदस्य हैं तो अपने सदस्य आईडी कार्ड के पीछे दिए गए नंबर या 1-800-565-9140 (TTY: 1-800-848-0298) पर सदस्य सेवा नंबर पर फोन करें।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
Если Вы являетесь участником, позвоните в отдел обслуживания участников по номеру, указанному на обратной стороне Вашей идентификационной карты участника, или по номеру 1-800-565-9140 (TTY: 1-800-848-0298).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
درصورتیکه عضو هستید، با شماره خدمات اعضا در پشت کارت شناسایی عضو خود یا 1-800-565-9140 (TTY: 1-800-848-0298) تماس بگیرید.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou.
Si ou se yon manm, rele nimewo Sèvis Manm ki sou do kat ID Manm ou an oswa 1-800-565-9140 (TTY: 1-800-848-0298).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej.
Członkowie mogą dzwonić pod numer działu Member Service podany na odwrocie karty identyfikacyjnej członka lub numer 1-800-565-9140 (TTY: 1-800-848-0298).

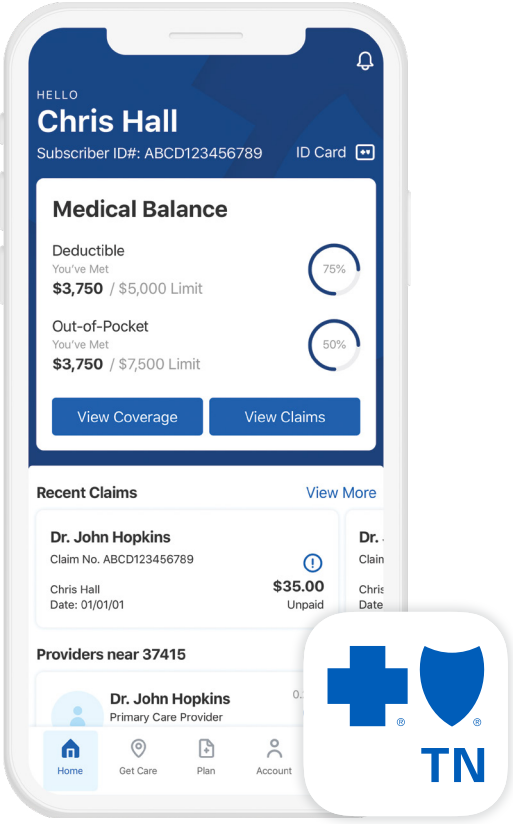
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis.
Caso seja membro, ligue para o telefone do serviço de Atendimento ao Membro informado no verso de seu cartão de identificação de membro ou para 1-800-565-9140 (TTY: 1-800-848-0298).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti.
Se è un membro, chiami il numero del Servizio per i membri riportato sul retro della Sua scheda identificativa del membro oppure il numero 1-800-565-9140 (TTY: 1-800-848-0298).

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló.
Naaltsoos bee ná ha'dít'éego, Naaltsoos Bá Hada'dít'éhígíí ninaaltsoos nitł'ízí bee nééhozinígíí bine'dęę' Naaltsoos Bá Hada'dít'éhígíí Bee Áka'anída'awo'í bibéésh bee hane'í biká'ígíí bee hodílnih doodago 1-800 -565-9140 (Doo Adinits'agóógo ǫ TTY: 1-800-848-0298) bee hodíilnih.

# We've got you covered.

## The BlueCross BlueShield of Tennessee app makes it easier than ever to get the health information you need, when you need it.




With our user-friendly design you get:

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- **Digital ID Card:** See and share your member ID card with a single tap
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