



Benefit Features

Annual Deductible

	Network Providers	Out-of-Network Providers [3]
Individual	\$500	\$1,000
Two - Person	\$1,000	\$2,000
Family	\$1,000	\$2,000

Annual Out-of-Pocket Maximum Amount

	Network Providers	Out-of-Network Providers [3]
Individual	\$2,000	\$4,000
Two - Person	\$3,000	\$6,000
Family	\$3,000	\$6,000

Dependent Age Limit

To age 19 or 25 if full-time student

Lifetime Maximum Benefit

Network Providers	Out-of-Network Providers [3]
\$2,000,000	\$2,000,000

Pre-Existing Waiting Period [2]

12 months

Benefits for Covered Services

Network Benefits

Out-of-Network Benefits [3]

Practitioner Office Services

	Network Benefits	Out-of-Network Benefits [3]
Office Visits	80% after Deductible	60% after Deductible
Maternity Office Visits	80% after Deductible	60% after Deductible
Routine Diagnostic Lab, X-Ray, & Injections	80% after Deductible	60% after Deductible
Non-routine Diagnostic Services [6]	80% after Deductible	60% after Deductible
Provider-Administered Specialty Pharmacy Products [10]	80% after Deductible	60% after Deductible

Preventive Health Care Services

	Network Benefits	Out-of-Network Benefits [3]
Well Child Care (under age 6)	80% after Deductible	60% after Deductible
Annual Well Woman Exam	80% after Deductible	60% after Deductible
Annual Mammography Screening	80% after Deductible	60% after Deductible
Annual Cervical Cancer Screening	80% after Deductible	60% after Deductible
Prostate Cancer Screening	80% after Deductible	60% after Deductible
Immunizations (under age 6)	80% after Deductible	60% after Deductible

Services Received at a Facility (includes professional and facility charges)

	Network Benefits	Out-of-Network Benefits [3]
Inpatient Services [4]	80% after Deductible	60% after Deductible
Outpatient Surgery [5]	80% after Deductible	60% after Deductible
Routine Diagnostic Services-Outpatient	80% after Deductible	60% after Deductible
Non-routine Diagnostic Services-Outpatient [6]	80% after Deductible	60% after Deductible
Provider-Administered Specialty Pharmacy Products [10]	80% after Deductible	60% after Deductible
Other Outpatient Services [7]	80% after Deductible	60% after Deductible
Emergency Care Services	80% after Deductible	60% after Deductible

Medical Equipment

	Network Benefits	Out-of-Network Benefits [3]
Durable Medical Equipment, Prosthetic & Orthotic Appliances	80% after Deductible	60% after Deductible

Therapeutic Services [8]

	Network Benefits	Out-of-Network Benefits [3]
Therapy (Limited to 30-36 visits per year per therapy type)	80% after Deductible	60% after Deductible

Skilled Nursing Facility & Rehabilitation Facility Services [4]

	Network Benefits	Out-of-Network Benefits [3]
Limited to 60 days combined	100%	60% after Deductible

Home Health Services [9]

	Network Benefits	Out-of-Network Benefits [3]
Limited to 60 visits per year	100% after Deductible	60% after Deductible

Hospice Services

Network Benefits	Out-of-Network Benefits [3]
100%	60% after Deductible

Ambulance Service

Network Benefits	Out-of-Network Benefits [3]
80% after Deductible	60% after Deductible

Notes:

- The following coinsurance apply to the in-network OOP max: inpatient hospital, outpatient surgery, non-routine diagnostics, ER, ambulance and DME.
- HIPAA regulations apply. A Group enrollee's pre-existing condition waiting period can be reduced by the enrollee's applicable 'creditable coverage'.
- Out-of-network benefit payment based on BlueCross BlueShield of Tennessee maximum allowable charge. You are responsible for paying any amount exceeding the maximum allowable charge.
- Services require prior authorization. When using network providers outside Tennessee and all out-of-network providers, benefits will be reduced to 50% if prior authorization is not obtained and services are medically necessary. If services are not medically necessary no benefits will be provided.
- Surgeries include invasive diagnostic procedures such as colonoscopy and sigmoidoscopy.
- CAT scans, MRIs, nuclear medicine and other similar technologies require prior authorization.
- Includes services such as chemotherapy, radiation therapy, and renal dialysis.
- Physical, speech, manipulative, and occupational therapies are limited to 30 visits per therapy type per year. Cardiac and pulmonary rehabilitative therapies are limited to 36 visits per therapy type per year.
- Requires prior authorization.
- Refer to www.bcbst.com for Specialty Pharmacy Drug List.

Exclusions From Coverage

- Services or supplies not listed as Covered Services in the Evidence of Coverage (EOC);
 - Services or supplies that are not Medically Necessary and Appropriate or have not been authorized by the Plan;
 - Services or supplies that are Investigational in nature;
 - When more than one treatment alternative exists, each is Medically Appropriate and Medically Necessary, and each would meet Your needs, We reserve the right to provide payment for the least expensive Covered Service alternative.
 - Illness or injury resulting from war, which occurred before Your Coverage began under this EOC and which is Covered by veteran's benefit or other coverage for which You are legally entitled;
 - Self treatment or training;
 - Staff consultations required by hospital or other facility rules;
 - Services which are free;
 - Treatment of illness or injury related to Your participation in a felony, attempted felony, riot or insurrection;
 - Treatment of work related illness or injury, regardless of presence or absence of workers' compensation coverage. Exclusion does not apply to injuries or illnesses of an employee who is sole-proprietor of the Group, partner of the Group or corporate officer of the Group, provided the officer filed an election not to accept Workers' Compensation with the appropriate government department;
 - Personal, physical fitness, recreational or convenience items and services such as barber and beauty services, television, air conditioners, humidifiers, air filters, heaters, physical fitness equipment, saunas, whirlpools, water purifiers, swimming pools, tanning beds, weight loss programs, physical fitness programs, self-help devices which are not primarily medical in nature, even if ordered by a Practitioner;
 - Services or supplies received before Your effective date for Coverage with this Plan;
 - Services or supplies received after Your Coverage under this Plan ceases for any reason, even though the expenses relate to a condition that began while You were Covered;
 - Services or supplies received in a dental or medical department maintained by or on behalf of the employer, mutual benefit association, labor union or similar group;
 - Telephone or email consultations, or charges for failure to keep a scheduled appointment or charges to complete a claim form or to provide medical records;
 - Services for providing requested medical information or completing forms;
 - Court ordered examinations and treatment, unless Medically Necessary;
 - Room, board and general nursing care rendered on the date of discharge, unless admission and discharge occur on the same day;
 - Benefits for Pre-existing Conditions until any Pre-existing Condition Waiting Periods have been met;
 - Charges in excess of the Maximum Allowable Charge for Covered Services or any charges which exceed the Lifetime Maximum;
 - Any service stated in the EOC as a non-Covered Service or limitation;
 - Charges for services performed by a family member;
 - Any charges for handling fees;
 - Nicotine replacement therapy and aids to smoking cessation including, but not limited to, patches;
 - Safety items, or items to affect performance primarily in sports-related activities;
 - Services or supplies related to obesity, including surgical or other treatment of morbid obesity;
 - Services or supplies related to treatment of complications (except complications of pregnancy) that are a direct or closely related result of a Member's refusal to accept treatment, medicines, or a course of treatment that a Provider has recommended or has been determined to be Medically Necessary, including leaving an inpatient medical facility against the advice of the treating physician;
 - Services or supplies related to cosmetic services, including surgical or other services, drugs or devices;
 - Blepharoplasty and browplasty, except for correction of injury to the orbital area resulting from physical trauma or non-cosmetic surgical procedures (e.g., removal of malignancies), treatment of edema and irritation resulting from Grave's disease, or correction of trichiasis, ectropion, or entropion of the eyelids;
 - Services and charges related to the care of the biological mother of an adopted child, if the biological mother is not a Member. Services and charges relating to surrogate parenting;
 - Sperm preservation;
 - Orthognathic surgery;
 - Maintenance Care;
 - Private duty nursing;
 - Pharmacogenetic testing;
 - Treatment of sexual dysfunction, regardless of cause;
 - Removal of impacted teeth, including wisdom teeth;
 - Professional services for maternity delivery in a home setting or location other than a licensed hospital or birthing center;
 - Methadone maintenance therapy and buprenorphine maintenance therapy;
 - Cranial orthosis, including helmet or headband, for the treatment of plagiocephaly;
 - Office visits and physical exams for school, camp, employment, travel, insurance, marriage or legal proceedings, and related immunizations and tests;
 - Routine foot care for the treatment of flat feet, corns, bunions, calluses, toenails, fallen arches, weak feet or chronic foot strain;
 - Foot orthotics, shoe inserts and custom made shoes, except as required by law for diabetic patients or as a part of a leg brace;
 - Preventive services not listed as Covered;
 - Services not provided in accordance with the Plan's Medical Policy guidelines.
- Dental procedures, except as otherwise indicated in the EOC;
- Procedures which require precertification, Prior Authorization and/or special consent, in accordance with the Plan's Medical Policy for which Authorization was not provided;
 - Inpatient stays primarily for therapy (such as physical or occupational therapy);
 - Private room when not authorized by the Plan and room and board charges are in excess of semi-private room;
 - Emergency treatment of a chronic, non-emergency condition, where symptoms have existed over a period of time, and a prudent layperson who possesses an average knowledge of health and medicine would not believe it to be an Emergency;
 - Ambulance transportation for Your convenience, that is not essential to reduce the probability of harm to You, when You are not transported to a facility, or transfers between facilities that did not receive Prior Authorization from the Plan;
 - Behavioral Health Services except as specified in separate Rider;
 - Services or supplies that are designed to create a pregnancy, enhance fertility or improve conception quality, including but not limited to artificial insemination, in vitro fertilization, fallopian tube reconstruction, uterine reconstruction, assisted reproductive technology (ART) including but not limited to GIFT and ZIFT, fertility injections, fertility drugs, services for follow-up care related to infertility treatments;
 - Reversal of sterilization;
 - Induced abortion unless the health care Practitioner certifies in writing that the pregnancy would endanger the life of the mother, the pregnancy is a result of rape or incest, the fetus is not viable, or the fetus has been diagnosed with a lethal or otherwise significant abnormality;
 - Services, supplies or prosthetics primarily to improve appearance;
 - Surgeries to correct or repair the results of a prior surgical procedure, the primary purpose of which was to improve appearance;
 - Surgeries and related services to change gender;
 - Custodial, domiciliary or private duty nursing services;
 - Cognitive rehabilitation;
 - Therapy/Rehabilitative treatment beyond what can reasonably be expected to significantly improve health, including therapeutic treatments for ongoing maintenance or palliative care;
 - Enhancement therapy which is designed to improve Your physical status beyond Your pre-injury or pre-illness state;
 - Complementary and alternative therapeutic services, including, but not limited to massage therapy, acupuncture, craniosacral therapy, neuromuscular reeducation, vision exercise therapy, and cognitive rehabilitation;
 - Therapy modalities that do not require the attendance or supervision of a licensed therapist;
 - Behavioral therapy, play therapy, communication therapy, and therapy for self correcting language dysfunctions as part of speech therapy, physical therapy or occupational therapy programs;
 - Organ transplant and related services that were not Authorized through Transplant Case Management;
 - Transplant related charges in excess of the Transplant Maximum Allowable Charge;
 - Removal of an organ from a Member for purposes of transplantation into another person, except as Covered by the Donor Organ Procurement provision;
 - Treatment for routine dental care and related services including, but not limited to crowns, caps, plates, bridges, dental x-rays, fillings, tooth extraction, periodontal surgery, prophylactic removal of teeth, root canals, preventive care (cleanings, x-rays), replacement of teeth (including implants, false teeth, bridges), bone grafts (alveolar surgery), treatment of injuries caused by biting and chewing, treatment of teeth roots and treatment of gums surrounding the teeth;
 - Treatment for correction of underbite, overbite, and misalignment of the teeth including but not limited to, braces for dental indications, orthognathic surgery, and occlusal splints;
 - Diagnostic Services which are not Medically Necessary and Appropriate;
 - Diagnostic Services not ordered by a Practitioner;
 - Pharmaceuticals purchased with a prescription except those dispensed at a participating facility, unless listed in a separate rider;
 - Pharmaceuticals that may be purchased without a prescription;
 - Self-administered Specialty Pharmacy Products as identified on the Plan's specialty pharmacy list, except as may be Covered by a separate Rider;
 - Services, surgeries and supplies to detect or correct refractive errors of the eyes;
 - Eyeglasses, contact lenses and examinations for the fitting of eyeglasses and contact lenses;
 - Eye exercises and/or therapy;
 - Visual training;
 - Charges exceeding the total cost of the Maximum Allowable Charge to purchase Durable Medical Equipment;
 - Unnecessary repair, adjustment or replacement or duplicates of any such equipment;
 - Supplies and accessories that are not necessary for the effective functioning of the covered equipment;
 - Items to replace those which were lost, damaged, stolen or prescribed as a result of new technology;
 - Items which require or are dependent on alteration of home, workplace or transportation vehicle;
 - Motorized scooters, exercise equipment, hot tubs, pool, saunas;
 - "Deluxe" or "enhanced" equipment;
 - Diabetic treatments or supplies that are not prescribed and certified by a Practitioner as being Medically Necessary;
 - Diabetic Supplies not required by state statute;
 - Hearing aids;
 - Prosthetics primarily for cosmetic purposes, including but not limited to wigs, or other hair prosthesis or transplants;
 - Replacement of contacts after the initial pair have been provided following cataract surgery;
 - Items such as non-treatment services or routine transportation, homemaker or housekeeping services, behavioral counseling, supportive environmental equipment, Maintenance Care or Custodial Care, social casework, meal delivery, personal hygiene, and convenience items;
 - Services such as homemaker or housekeeping services, meals, convenience or comfort items not related to the illness, supportive environmental equipment, private duty nursing, routine transportation and funeral or financial counseling;
 - Supplies that can be obtained without a prescription (except for diabetic supplies).

Please refer to the Evidence of Coverage for a complete description of PPO benefits and exclusions.



**BlueCross BlueShield
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0%/20%/30% Prescription Drug Plan after \$75 Brand-only Drug Deductible (\$750 Out of Pocket per year)

This plan has a “Brand-only” deductible. This means each calendar year you are responsible for the first \$75 of Brand Name Drugs before you can start purchasing your prescriptions at the Brand copay below. The “Brand-only” deductible is separate and will not apply toward satisfying any other deductible or out-of-pocket. For generic drugs, you pay only the coinsurance amounts shown below. Benefits are available for covered prescription drugs when filled by a BlueCross BlueShield of Tennessee participating pharmacy at the coinsurance below.

Generic Drugs- your coinsurance is 0%

Generic drugs offer the best value. A generic drug is a safe and effective alternative to a brand name drug. You pay nothing when you choose a generic drug. When your doctor writes your prescription, ask about using a generic drug.

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

Preferred Brand Drugs- your coinsurance is 20%

The Preferred Drug List is a list of therapeutically sound, cost-effective drugs, and is provided to encourage the use of certain drugs within a therapeutic class. When your doctor prescribes a preferred brand drug, your coinsurance is 20% after meeting the \$75 Brand Name Drug Deductible.

Non-Preferred Brand Drugs- your coinsurance is 30%

When your doctor prescribes a brand drug that is not on the Preferred Drug list, you pay the highest coinsurance of 30% after meeting a \$75 Brand Name Drug deductible.

Step Therapy

Step Therapy is a form of Prior Authorization. When Step Therapy is required, you must initially try a drug that has been proven effective for most people with your condition. This initial drug will be a Covered Generic Drug (if available) or a Preferred Brand Drug.

Pricing at Participating Pharmacies

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

Limitations

These limitations apply to each prescription order.

Benefits will be provided for

- up to a 30-calendar-day supply of prescription drugs, and/or
- up to a 90-calendar-day supply of maintenance prescription drugs listed on the BlueCross BlueShield of Tennessee maintenance drug list.
- up to a 90-calendar-day supply of prescription drugs obtained through home delivery and home delivery at retail.



Refills

Refills must be dispensed pursuant to a Prescription. If the number of refills is not specified in the Prescription, benefits for refills will not be provided beyond one year from the date of the original prescription.

The Plan has time limits on how soon a Prescription can be refilled. If you request a refill too soon, the Network Pharmacy will advise you when your Prescription benefit will cover the refill.

Prescription Home Delivery

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

Out-of-Network Pharmacies

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

A Broad Network of Retail Pharmacies

BlueCross BlueShield of Tennessee members access the Caremark network for retail pharmacy benefits. The RX04 pharmacy network provides tremendous accessibility with over 60,000 pharmacies nationally and over 1,500 in Tennessee, including every national chain and many independent pharmacies.

Self-Administered Specialty Pharmacy Network and Coverage

You have a separate network for Specialty Pharmacy Products: the specialty pharmacy network. You receive the highest level of benefits when you use a specialty pharmacy network provider for your self-administered Specialty Pharmacy Products. **Accredo Health Group**, **Caremark Specialty Pharmacy Services**, and **CuraScript Pharmacy/Priority Healthcare** are experienced in managing high-cost drugs and providing patient support for complex conditions such as Hepatitis C, Multiple Sclerosis, Arthritis and Hemophilia.

Accredo Health Group 1-888-239-0725 <i>(phone)</i> 1-866-387-1003 <i>(fax)</i>	Caremark Specialty Pharmacy Services 1-866-295-2779 <i>(phone)</i> 1-866-295-2778 <i>(fax)</i>	CuraScript Pharmacy/ Priority Healthcare 1-888-773-7376 <i>(phone)</i> 1-888-773-7386 <i>(fax)</i>
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You may purchase self-administered specialty pharmacy products from a retail pharmacy, but your copay will be higher. When purchasing self-administered Specialty Pharmacy Products from an Out-of-Network Pharmacy, you must pay all expenses and file a claim for reimbursement with us. You will be reimbursed based on the Maximum Allowable Charge, less any applicable Drug Copayment amount.

Please refer to the Specialty Pharmacy Products List to see which drugs are covered as self-administered specialty pharmacy products. Go to www.bcbst.com/Pharmacy.

Need More Information?

For more information on prescription drug coverage or our pharmacy programs call 1-800-565-9140. You can also visit the pharmacy section at www.bcbst.com.



Benefits will not be provided for:

- drugs for the treatment of onychomycosis (e.g., nail fungus), except for: 1) diabetics; or 2) immuno-compromised patients.
- growth hormones, except for: 1) treatment of absolute growth hormone deficiency in children whose epiphyses have not closed; 2) patients with “Turner” syndrome; and 3) patients with Prader-Willi syndrome confirmed by appropriate genetic testing;
- prescription and non-prescription medical supplies, devices and appliances, except for syringes used in conjunction with injectable medications or other supplies used in the treatment of diabetes and/or asthma;
- immunizations or immunological agents, including but not limited to: 1) biological sera, 2) blood, 3) blood plasma; or 4) other blood products are not Covered, except for blood products required by hemophiliacs.
- injectable drugs, unless: 1) intended for self-administration; or 2) defined by the Plan.
- drugs which are prescribed, dispensed or intended for use while You are confined in a hospital, skilled nursing facility or similar facility, except as otherwise Covered in the EOC;
- any drugs, medications, Prescription devices or vitamins, available over-the-counter that do not require a Prescription by Federal or State law, except as otherwise Covered in the EOC;
- any quantity of Prescription Drugs which exceeds that specified by the Plan’s P & T Committee;
- any Prescription Drug purchased outside the United States, except those authorized by Us;
- any Prescription dispensed by or through a non-retail internet Pharmacy;
- contraceptives which require administration or insertion by a Provider (e.g., non-drug devices, implantable products such as Norplant, except injectables), except as otherwise Covered in the EOC;
- medications intended to terminate a pregnancy (e.g., RU-486);
- non-medical supplies or substances, including support garments, regardless of their intended use;
- artificial appliances;
- allergen extracts;
- any drugs or medicines dispensed more than one year following the date of the Prescription;
- Prescription Drugs You are entitled to receive without charge in accordance with any worker’s compensation laws or any municipal, state, or federal program;
- replacement Prescriptions resulting from lost, spilled, stolen, or misplaced medications (except as required by applicable law);
- drugs dispensed by a Provider other than a Pharmacy;
- administration or injection of any drugs;
- Prescription Drugs used for the treatment of infertility;
- Prescription Drugs not on the Drug Formulary;
- anorectics (any drug or medicine for the purpose of weight loss and appetite suppression);
- nicotine replacement therapy and aids to smoking cessation including, but not limited to, patches;
- all newly FDA approved drugs prior to review by the Plan’s P & T Committee;
- any Prescription Drugs or medications used for the treatment of sexual dysfunction, including but not limited to erectile dysfunction (e.g. Viagra), delayed ejaculation, anorgasmia and decreased libido;
- Prescription Drugs used for cosmetic purposes including, but not limited to: 1) drugs used to reduce wrinkles (e.g. Renova); 2) drugs to promote hair-growth; 3) drugs used to control perspiration; 4) drugs to remove hair (e.g. Vaniqa); and 5) fade cream products;
- FDA approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia;
- Compound drugs filled or refilled at an Out-of-Network Pharmacy;
- drugs used to enhance athletic performance;
- Experimental and/or Investigational Drugs;
- Provider-administered Specialty Pharmacy Products, as indicated on Our Specialty Pharmacy Products list; and
- Prescription Drugs or refills dispensed:
 - in quantities in excess of amounts specified in the BENEFIT PAYMENT section;
 - without Our Prior Authorization when required; or
 - which exceed any applicable Annual Maximum Benefit, or any other maximum benefit amounts stated in this Rider or the EOC.

These exclusions only apply to this Rider. Items that are excluded under the Rider may be Covered as medical supplies under the EOC. Please review your EOC carefully.

Behavioral Health Benefits Mental Health/Substance Abuse Treatment

30/35 I

Inpatient: 30 days per calendar year

In-network.....80% subject to deductible

Out-of-network....60% subject to deductible

Outpatient: 35 visits per calendar year

In-network.....50% subject to deductible

Out-of-network....50% subject to deductible

**Inpatient Services require prior authorization. When an out-of-network facility is used and prior authorization is not obtained and the admission is determined to be medically necessary, benefits are provided at 50% of the maximum allowable charge after the deductible. Benefits will not be provided if the admission is determined to be not medically necessary.*

Inpatient care management is included.

Mental Health Medication Management Benefit

Outpatient behavioral health visits for the purpose of Medication Management do not count toward the number of mental health outpatient visits per year. Medication Management includes prescription, use and review of medication.

Please remember that all inpatient behavioral health care, both routine and emergency, must be authorized by BlueCross BlueShield of Tennessee's Behavioral Health Services.

Emergency Care

In an emergency, go to the nearest network facility or to the emergency room of the closest medical hospital. An emergency admission to the hospital does not need prior authorization, but you or the hospital must call Behavioral Health Services within 24 hours.

Access To Services

If you or a covered family member needs help, call the Behavioral Health Services Help Line phone number listed on the back of your BlueCross Blue Shield of Tennessee ID card. **This toll-free number offers assistance 24 hours a day, seven days a week, 365 days a year.**

For inpatient referral and authorization please call the telephone number on the back of your ID card and a care manager will direct you to a participating provider. For outpatient care, consult your directory to determine whether a particular provider is in the network. If you choose to use providers who are not in the behavioral health network, your benefits may be reduced. Behavioral health providers include experienced professionals, programs, and facilities to meet your needs. Any information you provide will be confidential.

If you are outside the State of Tennessee and need behavioral health care you must:

- For Inpatient care, have the hospital call Behavioral Health Services within 24 hours.
- To determine the network status of a provider in the state in which you wish to seek care, call the Behavioral Health Services number on the back of your ID card and ask to speak with a BlueCross BlueShield of Tennessee customer service representative. This call should be made between the hours of 8:30 a.m. and 5:30 p.m. EST, Monday through Friday.

Case Management

Case Management will be offered to individuals with chronic or catastrophic illnesses who are in inpatient levels of care.



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Extended Well Care

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

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

All well care benefits listed are subject to the terms, conditions, limitations, and exclusions contained in the Group Master Contract and the Evidence of Coverage. **All services covered by the Wellcare Rider are subject to normal contract benefits, which are determined by type of service and place of service. ***

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

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

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

***Important Note Regarding Colonoscopy and Sigmoidoscopy Benefits:**

All services covered by the Well Care Rider are subject to normal contract benefits, which are determined by type of service and place of service. When Well Care Rider services are provided in a physician's office, as the majority are, the office visit benefit applies. However, colonoscopy and sigmoidoscopy are invasive diagnostic surgical procedures, so surgery benefits apply to these services. **Sigmoidoscopies and colonoscopies performed in the physician's office are subject to the office surgery benefit** (copay or deductible/coinsurance, depending on the benefit plan). **Sigmoidoscopies and colonoscopies performed in an outpatient facility are subject to the outpatient surgery benefit** (usually deductible/coinsurance).