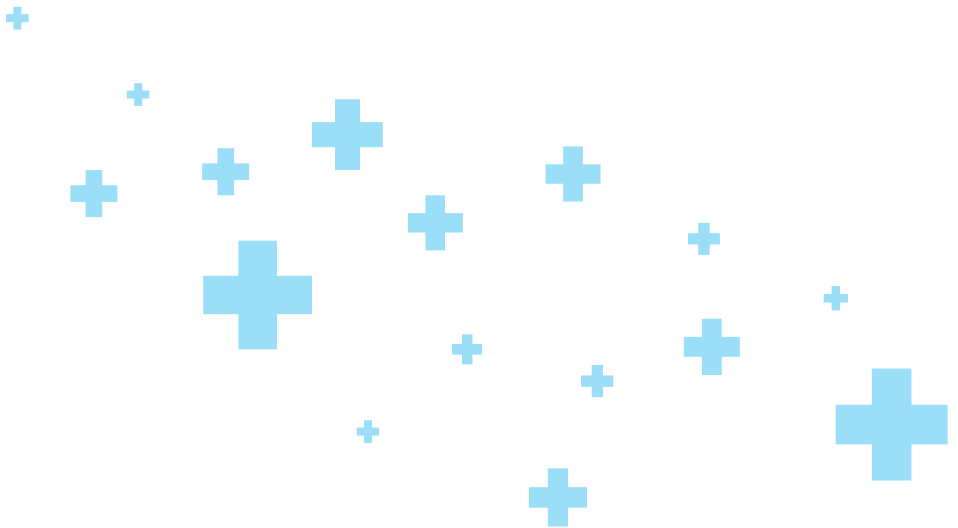

HealthyTNBabies

Member Handbook 2015

Group I

Do you need help in these languages: العربية (Arabic); Bosanski (Bosnian); کوردی - بادینانی (Kurdish-Badinani); کوردی - سۆرانی (Kurdish- Sorani); Soomali (Somali); Español (Spanish); Ngúói Việt (Vietnamese)? HealthyTNBabies language and member services are free at 1-888-325-8386, Monday-Friday, 8 a.m. to 6 p.m. ET. For TDD/TTY help call 1-866-591-2908. Federal and State laws protect your rights. They do not allow anyone to be treated in a different way because of: race, language, sex, age, color, birthplace, or disability. Need help? Call the Office of Non-Discrimination Compliance for free at 1-855-286-9085 or TTY dial 711 and ask for 855-286-9085.

HEALTHYTNBABIES MEMBER HANDBOOK

NOTICE

PLEASE READ THIS MEMBER HANDBOOK CAREFULLY AND KEEP IT IN A SAFE PLACE FOR FUTURE REFERENCE. IT EXPLAINS YOUR COVERAGE THROUGH HEALTHYTNBABIES. IF YOU HAVE ANY QUESTIONS ABOUT THIS MEMBER HANDBOOK OR ANY OTHER MATTER RELATED TO YOUR MEMBERSHIP IN THE PLAN, PLEASE WRITE OR CALL US AT:

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

¿Necesita un manual de HealthyTNBabies Program en español? Para conseguir un manual en español, llame a BCBST al (888) 325-8386 libre.

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

COVERKIDS HEALTHYTNBABIES
P.O. BOX 182261
CHATTANOOGA, TN 37422-7261

(866) 620-8864

(866) 447-0272 TTY

(866) 913-1046 FAX

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INTRODUCTION

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

PLEASE READ THIS MEMBER HANDBOOK CAREFULLY. It describes Your rights and duties as a Member. It is important to read the entire Member Handbook. Certain services are not covered by the Plan. Other Covered Services are limited. The Plan will not pay for any service not specifically listed as a Covered Service, even if a health care provider recommends or orders that non-covered service. (see Attachments A-C.)

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

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

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

The State of Tennessee ("State") has entered into a Contract ("Contract") with Us for Us to perform certain administrative services for the Plan such as claims processing, customer service, and contracting from network providers. The State sponsors and funds the Plan. We do not assume any financial risk or obligation with respect to Plan claims. The Plan will also be using Our Provider Networks.

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

While the State has given Us the authority to make benefit determinations, the State also has the authority to make any final Plan determination. Both the State and We, as the plan administrator, also have the authority to interpret the terms of Your Coverage. We will be considered to have properly exercised that authority unless either party has abused its discretion when making such determinations.

PROVIDER NETWORK

Our Provider Network gives You a choice of doctors, hospitals and other health care providers. We have contracted with a network of health care institutions and professionals to provide health care services to You. These Providers, called Network Providers, agree to special pricing arrangements.

Your Plan provides benefits only when You use Network Providers. If You receive services from an Out-of-Network Provider, no benefits will be paid. You are responsible for all charges from an Out-of-Network Provider. Attachment C: Schedule of Benefits, shows Your benefits for services received from Network Providers. Attachment C also will show You that the same service might be paid differently depending on where You receive the service.

YOUR MEMBERSHIP IDENTIFICATION CARD

Once Your Coverage becomes effective, You will receive a membership identification (ID) card. Your membership ID card is the key to receiving the benefits of the Plan. Carry it with you at all times.

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

The Member service number is on Your membership ID card. This is an important phone number. Call this number if You have any questions. Also, call this number if You are receiving emergency hospital services from Providers outside of Tennessee to make sure all Prior Authorization procedures have been followed.

If Your membership ID card is lost or stolen, call the toll-free number listed on the front page of this Member Handbook. The Member service department will You get a new one or you can order your card online at www.bcbst.com via BlueAccess. You may want to record Your identification number in this Member Handbook.

Important: Your membership ID card should be presented at each visit to a physician's office, hospital, pharmacy or other health care facility.

EASY GUIDELINES FOR GETTING THE MOST FROM YOUR BENEFITS

1. Always carry Your membership ID card and show it before receiving medical care and Prescription medicines.
2. Always use Network Providers, including pharmacies, durable medical equipment suppliers and home infusion therapy Providers. See Attachment A for an explanation of a Network Provider. Call the Member service department to verify that a Provider is a Network Provider.
3. Be sure to ask Member service if the Provider is in the specific network shown on Your membership ID card. Since BCBST has several networks, a Provider may be in one BCBST network, but not in all of Our networks. Check out Our website, www.BCBST.com, for more information on Providers in each network.

4. To find doctors who speak other languages, call the Member service number on the back of Your ID card. You may also find doctors who speak other languages at www.BCBST.com under Find A Doctor.
5. Call the Member service number on the back of Your ID Card to request the translation of forms or documents related to Your medical care.
6. To help You understand if BCBST considers a recommended service to be Medically Necessary, please refer to Our Medical Policy Manual at www.bcbst.com/providers/mpm.shtml.
7. In a true Emergency, it is appropriate to go to an Emergency room (see Emergency definition in the Definitions Section of this Member Handbook.) However, most conditions are not Emergencies and are best handled with a call to Your doctor's office. You can also call Your doctor on nights and weekends when Your doctor provides a covering health care professional to return Your call.
8. Ask that Your Provider report any Emergency admissions to BCBST within 24 hours or the next week day.
9. Your Network Provider is responsible for obtaining any required Prior Authorization.
10. Get a second opinion before undergoing elective services.
11. Notify the State's Eligibility Contractor toll-free at (866) 620-8864 if changes in the following occur:
    a. Name.
    b. Address.
    c. Telephone number.
    d. Employment.
    e. Status of any other health insurance You might have.
    f. Marriage.
    g. Death.
12. There are many community resources that may be helpful to You. For information, please call the Member service number shown on Your membership ID card or visit Our web site at www.BCBST.com.

BENEFIT ADMINISTRATION ERROR

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

RELATIONSHIP WITH NETWORK PROVIDERS

A. Independent Contractors

Network Providers are not employees, agents or representatives of the Plan or Us. Network Providers contract with Us and We have agreed to pay them for rendering Covered Services to You. Network Providers are solely responsible for making all medical treatment decisions in consultation with their Member-patients. The Plan does not make medical treatment decisions under any circumstances. Network Providers are not Our employees, agents or representatives.

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

The Network Providers' participation agreements permit Network Providers to dispute the Plan's Coverage decisions if they disagree with those decisions. If Your Network Provider does not dispute a Coverage decision, You may request reconsideration of that decision as explained in the grievance procedure section of this Member Handbook. The participation agreement requires Network Providers to fully and fairly explain Coverage decisions to You, upon request, if You decide to request that We reconsider a Coverage decision.

We have established various incentive arrangements to encourage Network Providers to provide Covered Services to You in an appropriate and cost effective manner. You may request information about Your Provider's payment arrangement by contacting the Member service department.

B. Termination of Provider's Participation

We or a Network Provider may end Our relationship with each other at any time. A Network Provider may also limit the number of Members that he, she or it will accept as patients. We do not promise that any specific Network Provider will be available to render services while You are Covered by this Plan.

INDEPENDENT LICENSEE OF THE BLUECROSS BLUESHIELD ASSOCIATION

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

ELIGIBILITY

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

a. be a US citizen, or qualified non-citizen
b. live in Tennessee;
c. not be covered under any other health plan unless it does not provide maternity coverage;
d. meet the household income requirements; and
e. be screened for TennCare eligibility or access to other state-sponsored Coverage; or
f. not be a dependent of a state employee, or a K-12 teacher or full-time support staff.

ENROLLMENT

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

EFFECTIVE DATE OF COVERAGE

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

TERMINATION AND CONTINUATION OF COVERAGE

A. Termination

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

The State may terminate Your Coverage:

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

B. Right To Request A Hearing

You may appeal the termination of Your Coverage for cause, as explained in the Grievance Procedure section of this Member Handbook. The fact that You have appealed will not postpone or prevent Us from terminating Your Coverage. If Your Coverage is reinstated as part of the Grievance Procedure, You may submit to Us for consideration any claims for services rendered after Your Coverage was terminated, in accordance with the “Claims Procedure” section of this Member Handbook.

C. Payment For Services Rendered After Termination of Coverage

Services received after Coverage terminates are not Covered, even if those services are part of a series of treatments that started before Coverage terminated. If You receive Covered Services after the Coverage terminated, We or the Provider who rendered those services, may recover any charges for such services from You, plus any costs of recovering such charges, including attorney’s fees.

D. Modification or Termination by State

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

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

BLUECARD PROGRAM

When You are in an area where BCBST Network Providers are not available and You need emergency health care services or information about a BlueCross BlueShield physician or hospital, just call the BlueCard Doctor and Hospital Information Line at 1-800-810-BLUE (2583). We will help You locate the nearest BlueCard Participating Provider.

In the BlueCard Program, the term, “Host Plan” means the BlueCross BlueShield Plan that provides access to service in the location where You need emergency health care services.

Show Your membership ID card (that has the “suitcase” logo) to any BlueCard Participating Provider. The BlueCard Participating Provider can verify Your membership, eligibility and Coverage with Your BlueCross BlueShield Plan. When You visit a BlueCard Participating Provider, You should not have claim forms to file. After You receive services, Your claim is electronically routed to BCBST, which processes it and sends You a detailed explanation of benefits. You are responsible for any applicable Copayments, or Your Deductible and Coinsurance payments (if any).

If You receive non-emergency services from an Out-of-Network Provider, You will be responsible for the full payment of the Out-of-Network Provider’s charge. No Benefits are payable for services received from Out-of-Network Providers. The calculation of Your liability for claims incurred outside the BCBST service area which are processed through the BlueCard program will typically be at the lower of the provider's Billed Charges or the negotiated price BCBST pays the Host Plan for covered services.

The negotiated price paid by BCBST to the Host Plan for covered health care services provided through the BlueCard Program may represent either: (a) the actual price paid by the Host Plan on such claims; (b) an estimated price that factors into the actual price, expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the on-site Plan's health care Providers or one or more particular Providers; or (c) a discount from Billed Charges representing the on-site Plan's expected average savings for all of its Providers or for a specified group of Providers. The discount that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price.

Plans using either the estimated price or average savings factor methods may prospectively adjust the estimated or average price to correct for over- or underestimation of past prices. However, the amount You pay is considered a final price.

In addition, laws in certain states may require BlueCross and/or BlueShield Plans to use a basis for calculating Member liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Thus, if You receive Covered Services in these states, Your liability for Covered Services will be calculated using these states' statutory methods.

REMEMBER: You are responsible for receiving Prior Authorization from BCBST for inpatient services received outside Tennessee. If Prior Authorization is not received, Your benefits will be denied.

Call the toll-free number on Your membership ID card for Prior Authorization. In case of an Emergency, You should seek immediate care from the closest health care provider.

CLAIMS AND PAYMENT

When You receive Covered Services, either You or the Provider must submit a claim form to Us. We will review the claim, and let You, or the Provider, know if We need more information, before We pay or deny the claim.

A. Claims

Federal regulations use several terms to describe a claim: pre-service claim; post-service claim; and a claim for Emergency Care.

1. A pre-service claim is any claim that requires approval of a Covered Service in advance of obtaining medical care as a condition of receipt of and payment for a Covered Service, in whole or in part.
2. A post-service claim is a claim for a Covered Service that is not a pre-service claim – the medical care has already been provided to You. Only post-service claims can be billed to the Plan, or You.
3. Emergency Care is medical care or treatment that, if delayed or denied, could seriously jeopardize: (1) the life or health of the claimant; or (2) the claimant's ability to regain maximum function. Emergency Care is also medical care or treatment that, if delayed or denied, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the medical care or treatment.

B. Claims Billing

1. You should not be billed or charged for Covered Services rendered by Network Providers, except for required Member Copayments. The Network Provider will submit the claim directly to Us.
2. You may be charged or billed by an Out-of-Network Provider for Services rendered by that Provider. If You use an Out-of-Network Provider, You are responsible for all charges.
3. If You obtain services from an Out-of-Network Provider in the event of a true emergency, the Out-of Network Provider may or may not file a claim for You. If You are charged or receive a bill, You must submit a claim to be considered for benefits. You must submit the claim within 120 days from the date the service was received or it will not be considered. If it is not reasonably possible to submit the claim within 120 days, it may be considered if You have a valid reason for not submitting the claim by the deadline.
4. A Network Provider may refuse to render a service, or reduce or terminate a service that has been rendered, or require You to pay for what You believe should be a Covered Service. If this occurs:
   a. You may submit a claim to Us to obtain a Coverage decision concerning whether the Plan will Cover that service. For example, if a pharmacy (1) does not provide You with a prescribed medication; or (2) requires You to pay for that prescription, You may submit a claim to the Plan to obtain a Coverage decision about whether it is Covered by

the Plan.

b. You may request a claim form from Our Member service department. We will send You a claim form within 2 business days. We may request additional information or documentation if it is reasonably necessary to make a Coverage decision concerning a claim.

C. Payment

1. When You receive Covered Services from a Network Provider, We pay the Network Provider directly. These payments are made according to Our agreement with that Network Provider. You authorize payment of benefits to that Network Provider.
2. If You received Covered Services from an Out-of-Network Provider, You are responsible for the full payment of the Out-of-Network Provider's charge.
3. We will pay benefits within 30 days after we receive a claim form that is complete. Claims are processed in accordance with current industry practices, and based on Our information at the time We receive the claim form.
4. When a claim is paid or denied, in whole or part, You will receive a Monthly Claims Statement (MCS). This will describe how much was paid to the Provider, and also let You know if You owe an additional amount to that Provider. The MCS will show the status of Your benefits. We will send the MCS monthly to the last address on file for You.
5. You are responsible for paying any applicable Copayment amount to the Provider.

Payment for Covered Services is more fully described in Attachment C: Schedule of Benefits.

D. Complete Information

Whenever You need to file a claim Yourself, We can process it more efficiently if You complete a claim form. This will ensure that You provide all the information needed. Most Providers will have claim forms or You can request them from Us by calling Our Member service department at the number listed on Your membership ID card.

Mail all claim forms to:

BCBST Claims Service Center
1 Cameron Hill Circle, Suite 0002
Chattanooga, Tennessee 37402-0002

PRIOR AUTHORIZATION, CARE MANAGEMENT, MEDICAL POLICY AND PATIENT SAFETY

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

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

A. Prior Authorization

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

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

Network Providers in Tennessee will request Prior Authorization for You.

You are responsible for requesting Prior Authorization when using Providers outside Tennessee and Out-of-Network Providers.

For the most current list of services that require Prior Authorization, call customer service.

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

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

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

B. Care Management - CaringStart®

Your health plan wants to help You have a healthy pregnancy! Our CaringStart Maternity Program can help. You are automatically enrolled in CaringStart as a Member of HealthyTNBabies. The program is voluntary and does not take the place of Your doctor’s care. We work with Your doctor to make sure You get the quality care and services that You need. CaringStart will give You important pregnancy-related health care information and health screenings that can identify health risks early in Your pregnancy. It provides You with the information that You need to care for Yourself during pregnancy,

such as practicing good nutrition, getting plenty of rest, exercising sensibly, and avoiding things that could harm You or Your baby.

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

So take steps now to help give Your baby the very best start in life! The CaringStart Team is available to answer Your questions and get You started in the program. You can contact them Monday through Friday, from 8 a.m. to 6 p.m. (ET) toll-free at **1-888-416-3025**. You may also call **1-888-416-3025** to disenroll from the CaringStart Program.

C. Medical Policy

Medical Policy looks at the value of new and current medical science. Its goal is to make sure that Covered Services have proven medical value.

Medical policies are based on an evidence-based research process that seeks to determine the scientific merit of a particular medical technology. Determinations with respect to technologies are made using technology evaluation criteria. “Technologies” means devices, procedures, medications and other emerging medical services.

Medical policies state whether or not a technology is Medically Necessary, Investigational or cosmetic. As technologies change and improve, and as Members’ needs change, We may reevaluate and change medical policies without formal notice. You may check Our medical policies at www.bcbst.com. Enter “medical policy” in the Search field. Our Medical Policies are made a part of this Member Handbook by reference.

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

D. Patient Safety

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

Care Management services, emerging health care programs and alternative treatment plans will be offered to eligible Members on a case-by-case basis to address their unique needs. Under no circumstances does a Member acquire a vested interest in continued receipt of a particular level of benefits. Offer or confirmation of Care Management services, emerging health care programs or alternative treatment plans to address a Member’s unique needs in one instance will not obligate Us to provide the same or similar benefits for any other Member.

SUBROGATION AND RIGHT OF REIMBURSEMENT

Subrogation Rights

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

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

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

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

Priority Right of Reimbursement

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

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

The Plan may notify those parties of its lien and right to reimbursement without

notice to or consent from You.

This priority right of reimbursement applies regardless of whether such payments are designated as payment for (but not limited to) pain and suffering, medical benefits, and/or other specified damages. It also applies regardless of whether You are a minor.

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

The Plan may enforce its rights of subrogation and recovery against, without limitation, any tortfeasors, other responsible third parties or against available insurance coverages, including underinsured or uninsured motorist coverages. Such actions may be based in tort, contract or other cause of action to the fullest extent permitted by law.

Notice and Cooperation

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

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

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

Legal Action and Costs

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

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

Settlement or Other Compromise

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

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

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

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

GRIEVANCE PROCEDURE

I. INTRODUCTION

We administer the Grievance Procedure for the Plan. Our Grievance procedure (the "Procedure") is intended to provide a fair, quick and inexpensive method of resolving any and all Disputes with the Plan. Such Disputes include: any matters that cause You to be dissatisfied with any aspect of Your relationship with the Plan; any Adverse Benefit Determination concerning a Claim; or any other claim, controversy, or potential cause of action You may have against the Plan. Please contact the Member service department at the number listed on Your membership ID card or (866) 591-2908 TTY/TDD: (1) to file a Claim; (2) if You have any questions about this Member Handbook or other documents that are related to Your Coverage (e.g. an explanation of benefits or monthly claims statement); or (3) to initiate a Grievance concerning a Dispute.

1. The Procedure can only resolve Disputes that are subject to the Plan's control.
2. You cannot use this Procedure to resolve a claim against a Provider for negligence. Network Providers are independent contractors. They are solely responsible for making treatment decisions in consultation with their patients. You may contact Us, however, to complain about any matter related to the quality or availability of services, or any other aspect of Your relationship with Providers.
3. An Adverse Benefit Determination is any denial, reduction, termination or failure to provide or make payment for what You believe should be a Covered Service. In addition, an Adverse Benefit Determination includes any rescission of Coverage or a denial of Coverage in an initial eligibility determination.
   a. If a Provider does not render a service, or reduces or terminates a service that has been rendered, or requires You to pay for what You believe should be a Covered Service, You may submit a Claim to Us to obtain a determination concerning whether the Plan will cover that service. As an example, if a pharmacy does not provide You with a prescribed medication or requires You to pay for that prescription, You may submit a Claim to Us to obtain a determination about whether it is Covered by the Plan. Providers may be required to hold You harmless for the cost of services in some circumstances.
   b. Providers may also appeal an Adverse Benefit Determination through the Plan's Provider dispute resolution procedure.
   c. Our determination will not be an Adverse Benefit Determination if: (1) a Provider is required to hold You harmless for the cost of services rendered; or (2) until We have rendered a final Adverse Benefit Determination in a matter being appealed through the Provider dispute resolution procedure.
4. You may request a form from Us to authorize another person to act on

Your behalf concerning a Dispute.

5. We and You may agree to skip one or more of the steps of this Procedure if it will not help to resolve Our Dispute.

6. Any Dispute will be resolved in accordance with applicable Tennessee or Federal laws and regulations, and this Member Handbook.

II. DESCRIPTION OF THE REVIEW PROCEDURES–MEDICAL RELATED APPEALS

A. Inquiry

An Inquiry is an informal process that may answer questions or resolve a potential Dispute. You should contact a Member service representative if You have any questions about how to file a Claim or to attempt to resolve any Dispute. Making an Inquiry does not stop the time period for filing a Claim or beginning a Dispute. You do not have to make an Inquiry before filing a Grievance.

B. Grievance

You must submit a written request asking Us to reconsider an Adverse Benefit Determination, or take a requested action to resolve another type of Dispute (Your "Grievance"). You must begin the Dispute process within 30 days from the date We issue notice of an Adverse Benefit Determination; or if no notice was sent, within 6 months from the date of the Adverse Benefit Determination. If You do not initiate a Grievance within this time frame, You may give up the right to take any action related to that Dispute.

Contact the Member service department at the number listed on Your membership ID card for assistance in preparing and submitting Your Grievance. They can provide You with the appropriate form to use in submitting a Grievance. This is the first level Procedure and is mandatory.

1. **Grievance Hearing**

   After We have received and reviewed Your Grievance, Our first level Grievance committee will meet to consider Your Grievance and any additional information that You or others submit concerning that Grievance. In Grievances concerning emergency care or pre-service Claims, the Plan will appoint one or more qualified reviewer(s) to consider such Grievances. Individuals involved in making prior determinations concerning Your Dispute are not eligible to be voting members of the first level Grievance committee or reviewers. The Committee or reviewers have full discretionary authority to make eligibility, benefit and/or claim determinations, pursuant to Your Coverage.

2. **Written Decision**

   The committee or reviewers will consider the information presented, and the chairperson will send You a written decision concerning Your

Grievance as follows:

(a) For a pre-service claim, within 30 days of receipt of Your request for review;

(b) For a post-service claim, within 30 days of receipt of Your request for review; and

(c) For a pre-service, emergency care claim, within 72 hours of receipt of Your request for review.

The decision of the Committee will be sent to You in writing and will contain:

(a) A statement of the committee's understanding of Your Grievance;

(b) The basis of the committee's decision; and

(c) Reference to the documentation or information upon which the committee based its decision. We will send You a copy of such documentation or information, without charge, upon written request.

C. State Informal Review

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

Appeals Coordinator - CoverKids
Division of Health Care Finance and Administration
310 Great Circle Road 2 West
Nashville, TN 37243

If Your request is not received by the Division of Health Care Finance and Administration within 8 days, You may give up the right to further review. It is a good idea to maintain a copy of all correspondence You send. Specific questions regarding the appeal process may be directed to the appeals coordinator at 615-253-9927 or 1-866-795-2001.

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

D. State Review Committee

If the informal review does not grant the relief requested, the request will be scheduled for review by the CoverKids/HealthyTNBabies Review Committee. The Committee will be composed of five members, including Division of Health Care Finance and Administration staff and at least one

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

E. Time for Reviews

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

III. DESCRIPTION OF THE REVIEW PROCEDURES - ELIGIBILITY RELATED APPEALS

A. Informal Review

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

B. Formal Review

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

Appeals Coordinator - CoverKids
Division of Health Care Finance and Administration
310 Great Circle Road 2 West
Nashville, TN 37243

Requests must be received by Division of Health Care Finance and Administration within 30 days of the issuance of the informal review decision. If Your request is not received within 30 days, You may give up

the right to further review. Receipts of requests for review will be acknowledged in writing within 10 days, including notification that a decision should be issued within one calendar month of receipt of the acknowledgment letter.

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

GENERAL PROVISIONS

A. Applicable Law

The laws of Tennessee govern this Plan.

B. Notices

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

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

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

C. Legal Action

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

D. Right to Request Information

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

E. Coordination of Benefits

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

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

F. Administrative Errors

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

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

DEFINITIONS

Defined terms are Capitalized. When defined words are used in this Member Handbook, they have the meaning set forth in this section. Words that are defined in Our Medical Policies and Procedures have the same meaning if used in this Member Handbook.

1. **Acute** - An illness or injury which is both severe and of short duration.
2. **Billed Charges** – The amount that a Provider charges for services rendered. Billed Charges may be different from the amount that BCBST determines to be the TennCare*Select* Maximum Allowable Charge for services.
3. **Brand Name Drug** - A Prescription Drug identified by its registered trademark or product name given by its manufacturer, labeler or distributor.
4. **Calendar Year or Plan Year** - The period of time beginning at 12:01 A.M. on January 1st and ending 12:00 A.M. on the following December 31st.
5. **Care Management** – A program that promotes cost effective coordination of care for Members with complicated medical needs, chronic illnesses, and/or catastrophic illnesses or injuries.
6. **Complications of Pregnancy** – Conditions requiring Hospital Confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or caused by pregnancy, such as Acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, non-elective cesarean section, ectopic pregnancy which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

   Complications of Pregnancy does not include false labor; occasional spotting; physician prescribed rest during the period of pregnancy; morning sickness; hyperemesis gravidarum (severe nausea, vomiting and dehydration) and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.
7. **Compound Drug** - An outpatient Prescription Drug, which is not commercially prepared by a licensed pharmaceutical manufacturer in a dosage form approved by the U.S. Food and Drug Administration (FDA) and which contains at least one ingredient classified as a Legend Prescription Drug.
8. **Concurrent Review Process** – The process of evaluating care during the period when Covered Services are being rendered.
9. **Copayment** – The dollar amount specified in Attachment C: Schedule of Benefits, that You are required to pay directly to a Provider for certain Covered Services. You must pay such Copayments at the time You receive those Services.
10. **Cosmetic Surgery** – Any treatment intended to improve Your appearance. Our Medical Policy establishes the criteria for what is cosmetic, and what is

Medically Necessary and Appropriate.

11. **Covered Services, Coverage or Covered** - Those Medically Necessary and Appropriate services and supplies that are set forth in Attachment A of this Member Handbook. Covered Services are subject to all the terms, conditions, exclusions and limitations of the Member Handbook.

12. **Custodial Care** - Any services or supplies provided to assist an individual in the activities of daily living as determined by Us including but not limited to eating, bathing, dressing or other self care activities.

13. **Drug Copayment/Copay** - The dollar amount that You must pay directly to the Network Pharmacy at the time the covered Prescription Drug is dispensed. The Drug Copayment must be paid for each Prescription Drug.

14. **Drug Formulary** - A list designating which Prescription Drugs and drug products are approved for reimbursement. This list is subject to periodic review and modification by Us.

15. **Emergency** – A sudden and unexpected medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect to result in:

    a. serious impairment of bodily functions; or

    b. serious dysfunction of any bodily organ or part; or

    c. placing the prudent layperson’s health in serious jeopardy.

    Examples of Emergency conditions include: (1) severe chest pain; (2) uncontrollable bleeding; or (3) unconsciousness.

16. **Emergency Care Services** - Those services and supplies that are Medically Necessary and Appropriate in the treatment of an Emergency.

17. **Enrollment Form** – A form or application, which must be completed in full for the eligible pregnant woman before she will be considered for Coverage under the Plan.

18. **Experimental and/or Investigational Drugs** – Drugs or medicines, which are labeled: “Caution – limited by federal law to Investigational use.”

19. **Generic Drug** - A Prescription Drug that has the same active ingredients, strength or concentration, dosage form and route of administration as a Brand Name Drug. The FDA approves each Generic Drug as safe and effective as a specific Brand Name Drug.

20. **Hospital Confinement or Hospital Admission** – When You are treated as a registered bed patient at a Hospital or other Provider facility and incur a room and board charge.

21. **Hospital Services** - Covered Services which are Medically Appropriate to be provided by an Acute care hospital.

22. **Inmate** – An individual confined in a local, state or federal prison, jail, youth

development center, or other penal or correctional facility, including a furlough from such a facility.

23. **Investigational Service** - A drug, device, treatment, therapy, procedure, or **other** service or supply that does not meet the definition of Medical Necessity or:

   a. cannot be lawfully marketed without the approval of the Food and Drug Administration ("FDA") when such approval has not been granted at that time of its use or proposed use, or

   b. is the subject of a current Investigational new drug or new device application on file with the FDA, or

   c. is being provided according to Phase I or Phase II clinical trial or the experimental or research portion of a Phase III clinical trial (provided, however, that participation in a clinical trial will not be the sole basis for denial), or

   d. is being provided according to a written protocol which describes among its objectives, determining the safety, toxicity, efficacy or effectiveness of that service or supply in comparison with convention alternatives, or

   e. is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board ("IRB") as required and defined by Federal regulations, particularly those of the FDA or the Department of Health and Human Services ("HHS"), or

   f. in the predominant opinion of experts, as expressed in the published authoritative literature, that usage should be substantially confined to research settings, or

   g. in the predominant opinion of experts, as expressed in the published authoritative literature, further research is necessary in order to define safety, toxicity, efficacy, or effectiveness of that Service compared with conventional alternatives, or

   h. the service or supply is required to treat a complication of an Experimental or Investigational Service.

   Our Medical Director has discretionary authority to make a determination concerning whether a service or supply is an Investigational Service. If Our Medical Director does not authorize the provision of a service or supply, it will not be a Covered Service. In making such determinations, Our Medical Director will rely upon any or all of the following, at his or her discretion:

   (1) Your medical records, or

   (2) the protocol(s) under which proposed service or supply is to be delivered, or

   (3) any consent document that You have executed or will be asked to execute, in order to receive the proposed service or supply, or

   (4) the published authoritative medical or scientific literature regarding the

proposed service or supply in connection with the treatment of injuries or illnesses such as those experienced by You, or

(5) regulations and other official publications issued by the FDA and HHS, or

(6) the opinions of any entities that contract with Us to assess and coordinate the treatment of Members requiring non-Experimental or Investigational Services, or

(7) the findings of the BlueCross and BlueShield Association Technology Evaluation Center or other similar qualified evaluation entities.

24. **Legend Drugs** – A drug that, by law, can be obtained only by Prescription and bears the label, "Caution: Federal law prohibits dispensing without a Prescription."

25. **Maintenance Care** – Skilled services including skilled nursing visits, skilled nursing facility care, physical therapy, occupational therapy and/or speech therapy for chronic, static or progressive medical conditions where the services: (1) fail to contribute toward cure; (2) fail to improve unassisted clinical function; (3) fail to significantly improve health; and (4) are indefinite or long-term in nature.

26. **Medical Director** - The physician designated by Us, or that physician's designee, who is responsible for the administration of Our medical management programs, including its authorization program.

27. **Medically Appropriate –** Services which have been determined by BCBST in its sole discretion to be of value in the care of a specific Member. To be medically appropriate, a service must meet all of the following:

    a. be Medically Necessary;

    b. be consistent with generally accepted standards of medical practice for the Member's medical condition;

    c. be provided in the most appropriate site and at the most appropriate level of service for the Member's medical condition;

    d. not be provided solely to improve a Member's condition beyond normal variation in individual development, appearance and aging:

    e. not be for the sole convenience of the Provider, Member or Member's family.

28. **Medically Necessary or Medical Necessity** – Services which have been determined by Us to be of proven value for use in the general and/or specialized population, as appropriate. To be Medically Necessary a service must:

    a. have final approval from the appropriate government regulatory bodies;

    b. have scientific evidence permitting conclusions concerning the beneficial effect of the service on health outcomes;

c. improve the net health outcome;

d. be as beneficial as any established alternative;

e. demonstrate the improvement outside the investigational setting; and

f. not be an experimental or Investigational service.

29. **Medicare** - Title XVIII of the Social Security Act, as amended, and coverage under this program.

30. **Member, You, Your** - An Eligible pregnant woman enrolled under the HealthyTNBabies program.

31. **Member Payment** - The Copayment amounts for Covered Services that You are responsible for as set forth in Attachment C: Schedule of Benefits. We may require proof that You have made any required Member Payment.

32. **Network Benefit** - Our payment level that applies to Covered Services received from a Network Provider. See Attachment C: Schedule of Benefits.

33. **Network Pharmacy** - A Pharmacy which has entered into a Participating Pharmacy Agreement with BCBST or its agent to provide Prescription Drug benefits to Members Covered under this Member Handbook, either in person or through home delivery.

34. **Network Provider** - A Provider who has contracted with Us to provide access to benefits to Members at specified rates. Such Providers may be referred to as Participating Providers, Participating Hospitals, etc.

35. **Non-Contracted Provider** - A provider that renders Covered Services to a Member but is in a specialty category or type with which We do not contract. A Non-Contracted Provider is different from an Out-of-Network Provider. A Non-Contracted Provider is not eligible to hold a contract with Us. Provider types that are considered Non-Contracted can change as We contract with different Provider types. A Provider's status as a Non-Contracted Provider, Network Provider, or Out-of-Network Provider can and does change. We reserve the right to change a Provider's status.

36. **Non-Routine Diagnostic Services** - Services such as CAT scans, MRIs, PET scans, nuclear medicine and other similar technologies.

37. **Out-of-Network Pharmacy** - A Pharmacy which has not entered into a service agreement with BCBST or its agent to provide benefits under this Member Handbook at specified rates to Members Covered under this Member Handbook.

38. **Out-of-Network Provider** - Any Provider who is an eligible Provider type but who does not have a contract with the Plan to provide Covered Services.

39. **Payor(s)** - An insurer, health maintenance organization, no-fault liability insurer, self-insured group, or other entity that provides or pays for a Member's health care benefits.

40. **Pharmacy** - A state or federally licensed establishment which is physically separate and apart from the office of a physician or authorized Practitioner,

and where Legend Drugs are dispensed by Prescription by a pharmacist licensed to dispense such drugs and products under the laws of the state in which he or she practices.

41. **Pharmacy and Therapeutics Committee or P&T Committee** - A panel of Our participating pharmacists, Network Providers, medical directors and pharmacy directors which reviews medications for safety, efficacy and cost effectiveness. The P&T Committee evaluates medications for addition and deletion from the: 1) Drug Formulary and 2) Quantity Limitation list. The P&T Committee may also set dispensing limits on medications.
42. **Practitioner** - A person licensed by the appropriate State to provide medical services.
43. **Prescription** - A written or verbal order issued by a physician or duly licensed Practitioner practicing within the scope of his or her licensure to a pharmacist [or dispensing physician] for a drug, or drug product to be dispensed.
44. **Prescription Drug** - A medication containing at least one Legend Drug which may not be dispensed under applicable state or federal law without a Prescription, and/or insulin.
45. **Prior Authorization, Authorized** - A review conducted by Us, prior to the delivery of certain services, to determine if such services will be considered Covered Services.
46. **Provider** - A person or entity that is engaged in the delivery of health services who, or that is licensed, certified or practicing in accordance with applicable State or Federal laws.
47. **Quantity Limitation** - Quantity limitations applied to certain Prescription Drug products as determined by the Pharmacy and Therapeutics Committee.
48. **Specialty Pharmacy Products** - Injectable, infusion and select oral medications that require complex care, including special handling, patient education and continuous monitoring. Specialty Pharmacy Products are listed on Our Specialty Pharmacy Products list. Specialty Pharmacy Products are categorized as provider-administered or self-administered.
49. **Subrogation** - The substitution of a third party (such as an insurance company or this Plan) in Your place to collect damages, debts or claims against someone who has injured You and caused You medical injuries.
50. **TennCare*Select* Maximum Allowable Charge** - The amount that We, with approval from the Bureau of TennCare, have determined to be the maximum amount payable for a Covered Service. That determination will be based upon Our contract with a Network Provider for Covered Services rendered by that Provider.

YOUR RIGHTS AND RESPONSIBILITIES

Your rights and responsibilities as a HealthyTNBabies Member

You have the right to:

- Be treated with respect and in a dignified way. You have a right to privacy and to have Your medical and financial information treated with privacy.
- Ask for and get information about HealthyTNBabies, its policies, its services, its caregivers, and members' rights and duties.
- Ask for and get information about how HealthyTNBabies pays its providers, including any kind of bonus for care based on cost or quality.
- Ask for and get information about Your medical records as the federal and state laws say. You can see Your medical records, get copies of Your medical records, and ask to correct Your medical records if they are wrong.
- Get services without being treated in a different way because of race, color, birthplace, language, sex, age, religion, or disability. You have a right to file a complaint if you think you have been treated unfairly. If you complain or appeal, You have the right to keep getting care without fear of bad treatment from Us, providers, or HealthyTNBabies.
- Get care without fear of physical restraint or seclusion used for bullying, discipline, convenience or revenge.
- Make appeals or complaints about HealthyTNBabies or Your care. The Grievance section of this Member Handbook tells You how.
- Make suggestions about Your rights and responsibilities or how HealthyTNBabies works.
- Choose providers in the network shown on Your membership ID card. You can turn down care from certain providers.
- Get medically necessary care that is right for You, when You need it. This includes getting emergency services, 24 hours a day, 7 days a week.
- Be told in an easy-to-understand way about Your care and all of the different kinds of treatment that could work for You, no matter what they cost or even if they aren't covered.
- Help to make decisions about Your health care.
- Make a living will or advance care plan and be told about Advance Medical Directives.
- Ask Us or HealthyTNBabies to look again at any mistake You think they make about getting on HealthyTNBabies or keeping your HealthyTNBabies or about getting Your health care.
- End your HealthyTNBabies coverage at any time.
- Exercise any of these rights without changing the way HealthyTNBabies or its providers treat You.

You are responsible for:

- Supplying information (to the extent possible) that We and Our practitioners or providers need in order to provide care.
- Following plans and instructions for care that you have agreed to with your practitioners or providers
- Understanding your health problems and participating in developing mutually agreed-upon treatment goals, to the degree possible.

FAIR DECISIONS ABOUT CARE

We work hard to earn and keep your trust. Whenever possible, We want to be an open book about how We make decisions. For Prior Authorizations and other health care decisions, We look at two factors:

- Whether the care or service suggested is appropriate for Your condition.
- Whether Your plan covers it.

Denying care, service or coverage is not rewarded by Us in any way to anyone, whether employees, vendors or contracted practitioners.

***** IMPORTANT PRIVACY INFORMATION *****

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH PLAN INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY. THEN,

KEEP IT ON FILE FOR REFERENCE.

LEGAL OBLIGATIONS

BlueCross BlueShield of Tennessee, Inc. and some subsidiaries and affiliates (BCBST) are required to maintain the privacy of all health plan information, which may include your: name, address, diagnosis codes, etc. as required by applicable laws and regulations (hereafter referred to as "legal obligations"); provide this notice of privacy practices to all members, inform members of the company's legal obligations; and advise members of additional rights concerning their health plan information. BCBST must follow the privacy practices contained in this notice from its effective date until this notice is changed or replaced.

BCBST reserves the right to change its privacy practices and the terms of this notice at any time, as permitted by the legal obligations. Any changes made in these privacy practices will be effective for all health plan information that is maintained, including health plan information created or received before the **changes are made**. All members will be notified of any changes by receiving a new notice of the company's privacy practices. You may request a copy of this notice of privacy practices at any time by contacting BCBST at the address on the back of this notice.

ORGANIZATIONS COVERED BY THIS NOTICE

This notice applies to the privacy practices of BlueCross BlueShield of Tennessee, Inc. and may apply to some subsidiaries and affiliates. Health plan information about members may be shared among these organizations as needed for treatment, payment or healthcare operations. As the company procures or creates new business lines, they may be required to follow the terms defined in this notice of privacy practices.

Subsidiaries or affiliates that do not receive or have access to your health plan information and are to be excluded from this notice of privacy practices include: The non-healthcare components of Golden Security Insurance Company, Southern Health Plan, Inc., and Tennessee Health Foundation Inc.

USES AND DISCLOSURES OF YOUR INFORMATION

Your health plan information may be used and disclosed for treatment, payment, and health care operations. For example:

TREATMENT: Your health plan information may be disclosed to a healthcare provider that asks for it to provide treatment.

PAYMENT: Your health plan information may be used or disclosed to pay claims for services or to coordinate benefits, which are covered under your health insurance policy.

HEALTH CARE OPERATIONS: Your health plan information may be used and disclosed to determine premiums, conduct quality assessment and improvement activities, to engage in care coordination or case management, accreditation, conducting and arranging legal services, fraud prevention and investigation, wellness, disease management, and for other similar administrative purposes.

AUTHORIZATIONS: You may provide written authorization to use your health plan information or to disclose it to anyone for any purpose. You may revoke your authorization in writing at any time. That revocation will not affect any use or disclosure permitted by your authorization while it was in effect. BCBST cannot use or disclose your health plan information except those described in this notice, without your written authorization. Examples of where an authorization would be required: Most uses and disclosures of psychotherapy notes (if recorded by a covered entity), uses and disclosures for marketing purposes, disclosures that constitute a sale of PHI, other uses and disclosures not described in this notice.

PERSONAL REPRESENTATIVE: Your health plan information may be disclosed to a family member, friend or other person as necessary to help with your health care or with payment for your health care. You must agree that the company may do so, as described in the Individual Rights section of this notice.

PLAN SPONSORS: Your health plan information, and the health plan information of others enrolled in your group health plan, may be disclosed to your plan sponsor in order to perform plan administration functions. Please see your plan documents for a full description of the uses and disclosures the plan sponsor may make of your health plan information in such circumstances.

UNDERWRITING: Your health plan information may be received for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a health insurance or benefits contract. If the company does not issue that contract, your health plan information will not be used or further disclosed for any other purpose, except as required by law; Additionally, health plans are prohibited from using or disclosing genetic information of an individual for underwriting purposes pursuant to the Genetic Information Nondiscrimination Act of 2008(GINA).

MARKETING: Your health plan information may be used to provide information about health-related benefits, services or treatment alternatives that may be of interest to you. Your health plan information may be disclosed to a business associate assisting us in providing that information to you. We will not market products or services other than health-related products or services to you unless you affirmatively opt-in to receive information about non-health products or services we may be offering. You have the right to opt out of fundraising communications.

RESEARCH: Your health plan information may be used or disclosed for research purposes, as allowed by law.

YOUR DEATH: If you die, your health plan information may be disclosed to a coroner, medical examiner, funeral director or organ procurement organization.

AS REQUIRED BY LAW: Your health plan information may be used or disclosed as required by state or federal law.

COURT OR ADMINISTRATIVE ORDER: Health plan information may be disclosed in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances.

VICTIM OF ABUSE: If you are reasonably believed to be a victim of abuse, neglect, domestic violence or other crimes, health plan information may be released to the extent necessary to avert a serious threat to your health or safety or to the health or safety of others. Health plan information may be disclosed, when necessary, to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

MILITARY AUTHORITIES: Health plan information of Armed Forces personnel may be disclosed to Military authorities under certain circumstances. Health plan information may be disclosed to authorized federal officials as required for lawful intelligence, counterintelligence, and other national security activities.

INDIVIDUAL RIGHTS

1. **DESIGNATED RECORD SET:** You have the right to look at or get copies of your health plan information, with limited exceptions. You must make a written request, using a form available from the Privacy Office, to obtain access to your health plan information. If you request copies of your health plan information, you will be charged 25¢ per page, $10 per hour for staff time required to copy that information, and postage if you want the copies mailed to you. If you request an alternative format, the charge will be based upon the cost of providing your health plan information in the requested format. If you prefer, the company will prepare a summary or explanation of your health plan information for a fee. For a more detailed explanation of the fee structure, please contact the Privacy Office. The company requires advance payment before copying your health plan information.
2. **ACCOUNTING OF DISCLOSURES:** You have the right to receive an accounting of any disclosures of your health plan information made by the company or a business associate for any reason, other than treatment, payment, or health care operations purposes within the past six years. This accounting will include the date the disclosure was made, the name of the person or entity the disclosure was made to, a description of the health plan information disclosed, the reason for the disclosure, and certain other information. If you request an accounting more than once in a 12-month period, there may be a reasonable cost-based charge for responding to those additional requests. Please contact the Privacy Office for a more detailed explanation of the fees charged for such accountings.
3. **RESTRICTION REQUESTS:** You have the right to request restrictions on the company's use or disclosure of your health plan information. The company is not required to agree to such requests. The company will only restrict the use or disclosure of your health plan information as set forth in a written agreement that is signed by a representative of the Privacy Office on behalf of the company.
4. **BREACH NOTICE:** You have the right to notice following a breach of unsecured protected health information. The notice of a breach of unsecured

protected health information shall at a minimum include the following: The date of the breach, the type of data disclosed in the breach, who made the non-permitted access, use or disclosure of unsecured protected health information and who received the non-permitted disclosure, and what corrective business action was or will be taken to prevent further non-permitted access, uses or disclosures of unsecured protected health information.

5. **CONFIDENTIAL COMMUNICATIONS:** If you reasonably believe that sending health plan information to you in the normal manner will endanger you, you have the right to make a written request that the company communicate that information to you by a different method or to a different address. If there is an immediate threat, you may make that request by calling a BlueCross BlueShield of Tennessee Customer Service Representative or the Privacy Office at 1-888-455-3824. Follow up with a written request is required as soon as possible. The company must accommodate your request if it is reasonable, specifies how and where to communicate with you, and continues to permit collection of premium and payment of claims under your health plan.
6. **AMENDMENT REQUESTS:** You have the right to make a written request that the company amend your health plan information. Your request must explain why the information should be amended. The company may deny your request if the health plan information you seek to amend was not created by the company or for other reasons permitted by its legal obligations. If your request is denied, the company will provide a written explanation of the denial. If you disagree, you may submit a written statement that will be included with your health plan information. If the company accepts your request, reasonable efforts will be made to inform the people that you designate about that amendment. Any future disclosures of that information will be amended.
7. **RIGHT TO REQUEST WRITTEN NOTICE:** If you receive this notice on the company's Web site or by electronic mail (e-mail), you may request a written copy of this notice by contacting the Privacy Office.

QUESTIONS AND COMPLAINTS

If you want more information concerning the company's privacy practices or have questions or concerns, please contact the Privacy Office.

If you are concerned that: (1) the company has violated your privacy rights; (2) you disagree with a decision made about access to your health plan information or in response to a request you made to amend or restrict the use or disclosure of your health plan information; (3) to request that the company communicate with you by alternative means or at alternative locations; please contact the Privacy Office. You may also submit a written complaint to the U.S. Department of Health and Human Services. The company will furnish the address where you can file a complaint with the U.S. Department of Health and Human Services upon request.

The company supports your right to protect the privacy of your health plan information. There will be no retaliation in any way if you choose to file a complaint with BlueCross BlueShield of Tennessee or subsidiaries and affiliates, or with the U.S. Department of Health and Human Services.

BlueCross BlueShield of Tennessee
The Privacy Office
1 Cameron Hill Circle
Chattanooga, Tennessee 37402-0001
Phone: (888) 455-3824
Fax: (423) 535-1976
E-mail: privacy_office@bcbst.com

YOUR RESPONSIBILITY TO REPORT FRAUD AND ABUSE

Most HealthyTNBabies Members and Providers are honest. But even a few dishonest people can hurt the HealthyTNBabies program. People who lie on purpose to get HealthyTNBabies may be fined or sent to jail.

If You find out about a case of fraud and abuse in the HealthyTNBabies program, You must tell Us about it. But You don't have to tell Us Your name.

Fraud and abuse for **HealthyTNBabies** can be things like:

- Lying about facts to get or keep HealthyTNBabies.
- Hiding any facts so that You can get or keep HealthyTNBabies.
- Letting someone else use Your HealthyTNBabies ID card.
- Selling or giving Your prescription medicines to anyone else.

Fraud and abuse for HealthyTNBabies providers can be things like:

- Billing HealthyTNBabies for services that were never given.
- Billing HealthyTNBabies twice for the same service.

To tell Us about fraud and abuse, **call the BlueCross BlueShield of Tennessee Confidential Compliance Hotline for free at 1-888-343-4221.**

Here are some other places that You can call or write to tell Us about fraud and abuse:

Agency Phone and Address

Office of Inspector General (OIG)
1-800-433-3982 toll-free
P.O. Box 282368
Nashville, TN 37228

Tennessee Bureau of Investigation (TBI)
1-800-433-5454 toll-free
901 R.S. Glass Blvd.
Nashville, TN 37216

You can also tell Us about fraud and abuse online at ComplianceHotline@bcbst.com.

NOTICE OF FAIR TREATMENT

Federal and State laws protect your rights. They do not allow anyone to be treated in a different way because of:

Race	Language	Sex	Age
Color	Birthplace	Disability	Religion

The Cover Tennessee Programs do not deny any person the right to have or work for CoverKids and HealthyTNBabies for the reasons listed above.

These laws give you these rights:

- Title VI of the Civil Rights Act of 1964 (42 USC 2000 *et seq.*),
- Section 504 of the Rehabilitation Act of 1973 (29 USC 794 *et seq.*),
- The Age Discrimination Act of 1975 (42 USC 6101 *et seq.*), and
- The Americans with Disabilities Act (42 USC 12101 *et seq.*).

Do you have questions? Need help? Do you want to file a complaint? Please contact:

Cover Tennessee Office of Non-Discrimination Compliance
ATTN: Director of Non-Discrimination Compliance
310 Great Circle Road, 4th Floor
Nashville, TN 37243

Phone: **Toll-Free (855) 286-9085** or

For TTY dial 711 and ask for 855-286-9085

Fax: (615) 253-2917

Do you need help in another language? العربية (Arabic); Bosanski (Bosnian); کوردی — بادینانی (Kurdish-Badinani); کوردی — سۆرانی (Kurdish- Sorani); Soomaali (Somali);

Español *(Spanish);* Nguơi Việt *(Vietnamese)*

Language help is free at (800) 758-1638.

CoverKids language and member services are free

Monday-Friday, 8 a.m. to 6 p.m. ET.

CoverKids and HealthyTNBabies members call 1-888-325-8386.

For TDD/TTY help call 1-866-591-2908.

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association

HOW TO REPORT A DISCRIMINATION COMPLAINT

Do you think you have been treated differently because of your race, color, birthplace, disability, age, sex, or religion? You or someone on your behalf can report a complaint with the Cover Tennessee Programs or BlueCross BlueShield of Tennessee, Inc. ("BCBST").

Complaints must be reported by 180 days (6 months) from the date you think you were treated in a different way. You may have more than 180 days to report your complaint if there is a good reason why you waited (like a serious illness or death in your family). The 180-day deadline may be increased if you can give a good reason for the delay in reporting your complaint to your Cover Tennessee Program.

A complaint may be reported by using the complaint page at **http://www.bcbst.com/members/cover-tennessee/fair_treatment/FairTreatmentComplaintForm_English.pdf** or by mailing a written complaint. This information must be on your complaint:

- **Your name, address and telephone number.** You must sign your name. If you file a complaint on someone's behalf, include your name, address, telephone number, and your relationship to that person--example: wife, sister, lawyer, friend.
- **Name and address of the program (CoverKids and HealthyTNBabies) you think treated you in a different way.**
- **How, why, and when you think you were treated in a different way.**
- **Any other important information.**

Do you have questions? Need help? Do you want to file a complaint? Please contact:

Cover Tennessee Office of Non-Discrimination Compliance
ATTN: Director of Non-Discrimination Compliance
310 Great Circle Road, 4th Floor
Nashville, TN 37243

Phone: **Toll-Free (855) 286-9085** or

For TTY dial 711 and ask for 855-286-9085

Fax: (615) 253-2917

Do you need help in another language? العربية *(Arabic);* Bosanski *(Bosnian);* کوردی – بادینانی *(Kurdish-Badinani);* کوردی – سۆرانی *(Kurdish- Sorani);* Soomaali *(Somali);*

Español *(Spanish);* Nguroi Việt *(Vietnamese)*

Language help is free at (800) 758-1638.

You can report a complaint to:

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

You can call: (404) 562-7453 TDD: (404) 562-7884

You can also write to:

U.S. DHHS / Region IV Office for Civil Rights
61 Forsyth Street, S.W - Suite 16T70
Atlanta, GA 30303-8904
Fax: (404) 562-7881

CoverKids language and member services are free

Monday-Friday, 8 a.m. to 6 p.m. ET.

CoverKids and HealthyTNBabies members call 1-888-325-8386.

For TDD/TTY help call 1-866-591-2908.

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association

DISCRIMINATION COMPLAINT

Federal and State laws do not allow the Cover Tennessee Programs to treat you differently because of your race, color, birthplace, disability, age, sex, and religion. Do you think you have been treated differently because of your **race, color, birthplace, disability, age, sex, or religion?** Use these pages to report a complaint to your Cover Tennessee Program.

The information marked with a star (*) must be on the complaint. If you need more room to tell us what happened, use other sheets of paper and mail them with your complaint.

1.* Write your name and address.

Name: ____

Address: ____

____ Zip: _______

Telephone: Home: (   ) _______________ Work or Cell: (   ) _______

Email Address: ____

2.* Are you reporting this complaint for someone else? ❑ Yes ❑ No

If Yes, who do you think was treated differently because of their **race, color,** birthplace**, disability, age, sex, or religion**?

Name: ____

Address: ____

____ Zip: _______

Telephone: Home: (   ) _______________ Work or Cell: (   ) _______

How are you related to this person(s) (wife, brother, friend, etc…)? _________

3.* The Cover Tennessee Program that you think treated you in a different way:

❑ CoverKids ❑ HealthyTNBabies

4.* How do you think you were treated in a different way? Was it your –

❑ Race ❑ Birthplace ❑ Color ❑ Sex ❑ Age

❑ Disability ❑ Religion ❑ Other (specify): ______________________

5. What is the best time to talk to you about this complaint? ________________

6.* When did this happen to you? Do you know the date?

Date it started: __/__/__ Date of the last time it happened: __/__/__

7. Complaints must be reported by 180 days (6 months) from the date you think you were treated in a different way. You may have more than 180 days to report your complaint if there is a good reason (like a death in your family or an illness) why you waited.

____

____

____

8.* Tell us what happened, how it happened and why you think it happened. Who did it? Was anyone else treated in a different way? You can write on more paper and send it in with these pages if you need more room.

____

____

____

9. Did anyone see you being treated differently? If so, please tell us their:

Name	Address	Telephone
		( )
		( )
		( )

10. Do you have any other information you want to tell us about?

____

____

____

11.*We cannot take a complaint that is not signed. Please write your name and the date on the line below. Are you the Personal Representative of the person who thinks they were treated differently? Please sign your name below. As a Personal Representative, you must attach a copy of the legal document giving you the right to act on behalf of this person.

Declaration: *I agree that the information in this complaint is true and correct and for Cover Tennessee to investigate my complaint.*

____ / /

(Sign your name here if you are the person this complaint is for) (Date)

____ / /

(Sign here if you are the Personal Representative) (Date)

Are you reporting this complaint for someone else but you are **not** the person's Personal Representative? Please sign your name below. The person you are reporting this complaint for must **also** sign the line above **or** must tell BCBST or his/her Cover Tennessee Program that it is okay for them to sign for him/her.

Declaration: *I agree that the information in this complaint is true and correct and for Cover Tennessee to investigate my complaint.*

____ / /

(Sign here if you reporting this for someone else) (Date)

It is okay to report a complaint to BCBST, CoverKids, or HealthyTNBabies. Information in this complaint is treated privately. Names or other information about people used in this complaint are shared only when needed. Please mail a signed Agreement to Release Information with your complaint. If you are filing this complaint on behalf of someone else, have that person sign an Agreement to Release Information and mail it with this complaint. Please mail the completed, signed Complaint Form **and** the signed Agreement to Release Information to:

Office of Non-Discrimination Compliance, Cover Tennessee Programs
Division of Health Care Finance and Administration
310 Great Circle Road, 4th Floor
Nashville, TN 37243

Be sure to make a copy of everything you send in and keep the copies for your records.

Do you have questions? Need help? Call (855) 286-9085 (toll-free) for help. For TTY dial 711 and ask for 855-286-9085. To get help in another language call:

العربية ***(Arabic);*** Bosanski ***(Bosnian);*** كوردی – بادینانی ***(Kurdish-Badinani);*** كوردی – سۆرانی ***(Kurdish- Sorani);*** Soomaali ***(Somali);*** **Espanol*(Spanish);*** Người Việt ***(Vietnamese)***

***(*800) 758-1638**

Or:

CoverKids language and member services are free

Monday-Friday, 8 a.m. to 6 p.m. ET.

CoverKids and HealthyTNBabies members call 1-888-325-8386.

For TDD/TTY help call 1-866-591-2908.

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association

Agreement to Release Information

To investigate your complaint, your Cover Tennessee Program and BlueCross BlueShield of Tennessee, Inc. ("BCBST") may need to tell other persons or agencies important to this complaint your name or other information about you.

To speed up the investigation of your complaint, read, sign, and mail one copy of this Agreement to Release Information with your complaint. Please keep one copy for yourself.

- I understand that during the investigation of my complaint the Cover Tennessee Program and BCBST may need to tell people my name or other information about me to other persons or agencies. For example, if I report that my doctor treated me in a different way because of my age, Cover Tennessee may need to talk to my doctor.
- You do not have to agree to release your name or other information. It is not always needed to investigate your complaint. But, if you don't agree to let us use your name or other details, it may stop the investigation of your complaint. And, we may have to close your case.

If you are filing this complaint for someone else, we need that person to sign the Agreement to Release Information. Are you signing this as a Personal Representative? Then you must also give us a copy of the legal documents appointing you as the Personal Representative.

By signing this Agreement to Release Information, I agree that I have read and understand my rights written above. I agree to Cover Tennessee Program, CoverKids and HealthyTNBabies telling people my name or other information about me to other persons or agencies important to this complaint during the investigation and outcome.

By signing this Agreement to Release Information, I agree that I have read and understand my rights written above. I agree to BCBST telling people my name or other information about me to other persons or agencies important to this complaint during the investigation and outcome.

This Agreement to Release Information is in place until the final outcome of your complaint. You may cancel your agreement at any time by calling or writing to your Cover Tennessee Program or to BCBST without canceling your complaint. If you cancel your agreement, information already shared cannot be made unknown.

Signature: ____ Date: __/__/__

Name: ____

Address: ____

____ Zip: _________

Telephone: Home: (_____)___________ Work or Cell: (_____)_______________

Do you have questions? Need help? Call:

The Cover Tennessee Programs at: (855) 286-9085 (toll-free). For TTY dial 711 and ask for 855-286-9085. To get help in another language call:

العربية ***(Arabic);*** Bosanski ***(Bosnian);*** كوردى — بادينانى ***(Kurdish-Badinani);*** كوردى — سۆرانى ***(Kurdish- Sorani);*** Soomaali ***(Somali);*** **Espanol*(Spanish);*** Nguơi Việt ***(Vietnamese)***

(800) 758-1638

Or

CoverKids language and member services are free

Monday-Friday, 8 a.m. to 6 p.m. ET.

CoverKids and HealthyTNBabies members call 1-888-325-8386.

For TDD/TTY help call 1-866-591-2908.

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association

Aviso de Trato Justo

Las leyes Federales y Estatales protegen sus derechos. Dichas leyes no permiten que nadie reciba un trato diferente debido a su:

Raza	Idioma	Sexo	Edad	Color de la piel
Lugar de nacimiento		Incapacidad	Religión	

Por las razones mencionadas anteriormente, los Programas que abarcan Cover Tennessee Programs, no le niegan a ninguna persona el derecho de tener o de trabajar para CoverKids y HealthyTNBabies.

Estas leyes le dan los siguientes derechos:

- El Título VI de la Ley de Derechos Civiles de 1964, (42 USC 2000 *et seq.*),
- La Sección 504 de la Ley de Rehabilitación de 1973, (29 USC 794 *et seq.*),
- La Ley de Discriminación por edad de 1975, (42 USC 6101 *et seq.*),
- La Ley para Estadounidenses con Discapacidades (42 USC 12101 *et seq.*),

¿Tiene usted preguntas? ¿Necesita ayuda? ¿Quiere presentar una queja? Por favor comuníquese con:

`La Oficina de Cumplimiento de Prevención de Discriminación de Cover Tennessee

ATTN: Director de la Oficina de Cumplimiento de Prevención de Discriminación de Cover Tennessee
310 Great Circle Road, 4th Floor
Nashville TN 37243

Por Teléfono: **Llame gratuitamente al (855) 286-9085.**

Para los usuarios de TTY, marque 711 y pida por 855-286-9085.

Fax: (615) 253-2917

¿Necesita usted ayuda en estos idiomas: العربية *(Árabe);* Bosanski *(Bosnio);* كوردی — بادینانی *(Kurdo-Badinani);* كوردی — سۆرانی *(Kurdo- Sorani);* Soomaali *(Somalí);* **Español** *(Spanish);* Nguơi Việt *(Vietnamice)?*

Reciba ayuda gratis en otros idiomas llamando al (800) 758-1638.

Los servicios en diferentes idiomas y los servicios de atención al cliente para los miembros de CoverKids son servicios gratuitos, de lunes a viernes, de 8 a.m. a 6 p.m., hora del este.

Los miembros de CoverKids y HealthyTNBabies pueden llamar al 1-888-325-8386.

Para recibir ayuda con TDD/TTY puede llamar al 1-866-591-2908.

BlueCross BlueShield of Tennessee, Inc., un Licenciatario Independiente de BlueCross BlueShield Association.

Cómo reportar una queja por Discriminación

¿Cree usted que lo han tratado de forma diferente debido a su raza, color de la piel, lugar de nacimiento, discapacidad, edad, sexo o religión? Usted o alguien en su nombre puede presentar una queja ante los Programas de Cover Tennessee o ante BlueCross BlueShield of Tennessee, Inc. ("BCBST").

Las quejas deben reportarse a los 180 días (6 meses) de la fecha en que usted cree que lo trataron de una manera diferente. Usted puede esperar más de 180 días para reportar su queja si es que hay una buena razón por la cual usted ha esperado hacerlo (tal como una enfermedad grave o muerte de alguien en su familia). El plazo de 180 días puede aumentar si usted tiene una buena razón para la demora en reportar su queja ante el Programa de Cover Tennessee.

Usted puede presentar una queja en la página de quejas del sitio: http://www.bcbst.com/members/cover-tennessee/fair_treatment/FairTreatmentComplaintForm_Spanish.pdf o puede enviar por correo una queja por escrito. Esta es la información que debe usar para presentar su queja:

- **Su nombre, domicilio y número de teléfono.** Debe firmar su nombre. Si usted presenta una queja en nombre de otra persona, incluya su nombre, domicilio, número de teléfono y la relación que tiene con dicha persona--por ejemplo: esposa, hermana, abogado, amigo.
- **Nombre y dirección del programa (CoverKids and HealthyTNBabies) que usted cree que lo trataron de una manera diferente.**
- **Cómo, porqué y cuándo usted cree que lo trataron de una manera diferente.**
- **Cualquier otra información importante.**

¿Tiene usted preguntas? ¿Necesita ayuda? ¿Quiere presentar una queja? Por favor comuníquese con:

La Oficina de Cumplimiento de Prevención de Discriminación
de Cover Tennessee
ATTN: Director de la Oficina de Cumplimiento de Prevención de Discriminación
de Cover Tennessee
310 Great Circle Road, 4th Floor
Nashville TN 37243

Por teléfono: **Llame gratuitamente al (855) 286-9085.** Para los usuarios de TTY, marque 711 y pida por 855-286-9085.

Fax: (615) 253-2917

¿Necesita usted ayuda en estos idiomas:

العربية *(Árabe);* Bosanski *(Bosnio);* كوردی — بادینانی *(Kurdo-Badinani);* كوردی — سۆرانی *(Kurdo- Sorani);* Soomaali *(Somalí);* **Español** *(Spanish);* Nguroi Việt *(Vietnamice)?*

Reciba ayuda gratis en otros idiomas llamando al (800) 758-1638.

Usted puede reportar una queja a la siguiente dirección:

Departamento de Salud y Servicios Humanos de los EE.UU. - Región IV de la Oficina de Derechos Civiles

Usted puede llamar a los números: (404) 562-7453 TDD: (404) 562-7884

También puede escribir a la siguiente dirección:

U.S. DHHS / Region IV Office for Civil Rights
61 Forsyth Street, S.W - Suite 16T70
Atlanta, GA 30303-8904

Fax: (404) 562-7881

Los servicios en diferentes idiomas y los servicios de atención al cliente para los miembros de CoverKids son servicios gratuitos, de lunes a viernes, de 8 a.m. a 6 p.m., hora del este.

Los miembros de CoverKids y HealthyTNBabies pueden llamar al 1-888-325-8386.

Para recibir ayuda con TDD/TTY puede llamar al 1-866-591-2908.

BlueCross BlueShield of Tennessee, Inc., un Licenciatario Independiente de BlueCross BlueShield Association.

QUEJA POR DISCRIMINACIÓN

Las leyes Federales y Estatales no permiten que los representantes de los Programas de Cover Tennessee lo traten de forma diferente debido a su raza, color de la piel, lugar de nacimiento, discapacidad, edad, sexo o religión. ¿Cree usted que lo han tratado de forma diferente debido a su **raza, color de la piel, lugar de nacimiento, discapacidad, edad, sexo o religión**? Utilice estas páginas para reportar cualquier queja al Programa de Cover Tennessee.

La información que está marcada con un asterisco (*) debe responderse en la queja. si necesita más espacio para decirnos lo que sucedió, utilice otras hojas de papel y envíelas con su queja.

1.* Escriba su nombre y su dirección.

Nombre: ______________________________
Dirección: ______________________________
______________________________ Código postal: ________
Teléfono: Casa: (_____)_________Trabajo o celular: (_____)____________
Dirección de correo electrónico: ______________________________

2.* ¿Está usted reportando esta queja en nombre de otra persona? ❑ Sí ❑ No

Si es así, ¿Quién cree usted que ha sido tratado de forma diferente debido a su **raza, color de la piel, lugar de nacimiento, discapacidad, edad, sexo o religión**?

Nombre: ______________________________
Dirección: ______________________________
______________________________ Código postal: ________
Teléfono: Casa: (_____)_________Trabajo o celular: (_____)____________
¿Qué relación tiene usted con esta persona(s) (conyugue, hermano, amigo, etc...)?______________________________

3.* Nombre del Programa de Cover Tennessee que usted cree que lo trataron de una manera diferente.

❑ CoverKids ❑ HealthyTNBabies

4.* ¿Cómo cree usted que lo trataron de una manera diferente? Fue debido a su –

❑ Raza ❑ Lugar de nacimiento ❑ Color de la piel ❑ Sexo

❑ Edad ❑ Discapacidad ❑ Discapacidad ❑ Discapacidad

❑ Otro (especifique): ______________________________
____

5. ¿Cuál es la mejor hora para hablar con usted sobre esta queja? _________

6.* ¿Cuándo le sucedió eso? ¿Sabe cuál es la fecha?

Fecha en que comenzó: ___/___/___

Fecha cuando sucedió por última vez: ___/___/___

7. Las quejas deben reportarse a los 180 días (6 meses) de la fecha en que usted cree que lo trataron de una manera diferente. Posiblemente usted tenga más de 180 días para reportar su queja si es que hay una buena razón por la cual usted ha esperado hacerlo (tal como una enfermedad o muerte de alguien en su familia).

____
____
____

8. Cuéntenos lo que ocurrió, ¿cómo sucedió y por qué cree usted que pasó? ¡Quién lo hizo! ¿Fue alguien más tratado de una manera diferente? Si necesita más espacio, usted puede escribir en papel adicional y enviarlo con estas páginas.

____
____
____

9. ¿Alguien vio que usted recibió un trato diferente? Si es así, por favor indique su:

Nombre	Dirección	Teléfono
		( )
		( )
		( )

10. ¿Tiene usted alguna otra información de la que nos quiera hablar?

____
____
____

11.* No podemos recibir una queja que no esté firmada. Por favor escriba su nombre y la fecha en la linea de abajo. ¿Es usted el Representante Personal de la persona que piensa que fue tratada de manera diferente? Por favor firme su nombre en la parte de abajo. Como Representante Personal, usted debe adjuntar una copia del documento legal que le ha dado el derecho de actuar en nombre de esta persona.

Declaración: Estoy de acuerdo en que la información contenida en esta queja es verdadera y correcta y acepto que Cover Tennessee investigue mi queja.

____ __/__/__
(Firme aquí si usted es la persona a quien se le está presentando esta queja)(Fecha)

____ __/__/__
(Firme aquí si usted es el Representante Personal) (Fecha)

¿Está usted reportando esta queja en nombre de otra persona pero usted **no** es el Representante Personal de esta persona? Por favor firme su nombre en la parte de abajo. La persona que está reportando la queja también debe firmar en la línea anterior o debe informar a BCBST o al Programa de Cover Tennessee que él o ella autoriza que firmen en su nombre. **Declaración:** Estoy de acuerdo en que la información contenida en esta queja es verdadera y correcta y acepto que Cover Tennessee investigue mi queja.

____ __/__/__
(Firme aquí si usted está reportando esto en nombre de otra persona) (Fecha)

No hay problema con reportar una queja ante BCBST, CoverKids, o HealthyTNBabies. La información contenida en esta queja se maneja privadamente. Los nombres u otra información sobre las personas que aparecen en esta queja se revelan solamente cuando es necesario hacerlo. Por favor envíe y firme el Acuerdo de Divulgación de Información junto con su queja. Si usted está presentando esta queja en nombre de otra persona, pídale a dicha persona que firme el Acuerdo de Divulgación de Información y que lo envíe con esta queja. Por favor envíe por correo, complete y firme el Formulario de Quejas **y** firme el Acuerdo de Divulgación de Información a la oficina de:

Non-Discrimination Compliance, Cover Tennessee Programs
Division of Health Care Finance and Administration
310 Great Circle Road, 4th Floor
Nashville, TN 37243

Asegúrese de hacer una copia de todo lo que envía y deje las copias para sus archivos.

¿Tiene alguna pregunta? ¿Necesita ayuda? Para recibir ayuda llame al (855) 286-9085 (llamada gratis). Para los usuarios de TTY, marque 711 y pida por 855-286-9085.

¿Necesita usted ayuda en estos idiomas:
العربية (Árabe); Bosanski (Bosnio); كوردی — بادینانی (Kurdo-Badinani); كوردی — سۆرانی (Kurdo- Sorani);
Soomaali (Somalí); **Español** (Spanish); Ngươi Việt (Vietnamice)?

Reciba ayuda gratis en otros idiomas llamando al (800) 758-1638.

Or

Los servicios en diferentes idiomas y los servicios de atención al cliente para los miembros de CoverKids son servicios gratuitos, de lunes a viernes, de 8 a.m. a 6 p.m., hora del este.

Los miembros de CoverKids y HealthyTNBabies pueden llamar al 1-888-325-8386.

Para recibir ayuda con TDD/TTY puede llamar al 1-866-591-2908.

BlueCross BlueShield of Tennessee, Inc., un Licenciatario Independiente de BlueCross BlueShield Association.

Acuerdo de Divulgación de Información

Para investigar su queja, el Programa de Cover Tennessee y BlueCross BlueShield of Tennessee, Inc. ("BCBST") podrían verse en la necesidad de darle su nombre u otra información suya a otras personas o agencias significativas a esta queja

Para acelerar la investigación de su queja, lea, firme y envíe por correo junto con su queja, una copia de este Acuerdo de Divulgación de Información. Por favor, guarde una copia para usted.

- Entiendo que durante la investigación de mi queja el Programa de Cover Tennessee y BCBST, posiblemente tengan que decirle a otras personas o agencias mi nombre u otra información sobre mi persona. Por ejemplo, si reporto que mi doctor me ha tratado de manera diferente debido a mi edad, Cover Tennessee posiblemente tenga que hablar con mi doctor.
- Usted no tiene que estar de acuerdo para que revelen su nombre u otra información. No siempre es necesario investigar su queja. Pero. si usted no está de acuerdo en dejarnos usar su nombre u otros detalles, esto podría detener la investigación de su queja. Y, tal vez tengamos que cerrar su caso

Si usted está presentando esta queja en nombre de otra persona, necesitamos que esta persona firme el Acuerdo de Divulgación de Información. ¿Está usted firmando este documente como un Representante Personal? A continuación, también tiene que enviarnos una copia de los documentos legales donde lo nombran como Representante Personal.

Al firmar este Acuerdo de Divulgación de Información, acepto que he leído y entiendo mis derechos escritos anteriormente. Estoy de acuerdo con que el Programa de Cover Tennessee CoverKids y HealthyTNBabies, den mi nombre u otra información sobre mí a otras personas o agencias significativas a esta queja durante la investigación y los resultados.

Al firmar este Acuerdo de Divulgación de Información, acepto que he leído y entiendo mis derechos escritos anteriormente. Estoy de acuerdo con que BCBST, dé mi nombre u otra información sobre mí a otras personas o agencias significativas a esta queja durante la investigación y los resultados.

Este Acuerdo de Divulgación de Información está vigente hasta tenga el resultado final de su queja. Usted puede cancelar su contrato en cualquier momento llamando o escribiendo a su Programa de Cover Tennessee o a BCBST sin cancelar su queja. Si usted cancela su acuerdo, la información ya divulgada no puede ser recuperada.

Firma: ____ Fecha: __/ /__

Nombre: ____

Dirección: ____

____ Código postal: _________

Teléfono: Casa: (_____)___________ Trabajo o celular: (_____)______________

¿Tiene alguna pregunta? ¿Necesita ayuda? Para los Programas de Cover Tennessee llame al: (855) 286-9085 (llamada gratis). Para los usuarios de TTY, marque 711 y pida por 1-855-286-9085.

¿Necesita usted ayuda en estos idiomas:

العربية *(Árabe);* Bosanski *(Bosnio);* كوردی – بادینانی *(Kurdo-Badinani);* كوردی – سۆرانی *(Kurdo- Sorani);* Soomaali *(Somalí);* **Español** *(Spanish);* Người Việt *(Vietnamice)?*

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Para recibir ayuda con TDD/TTY puede llamar al 1-866-591-2908.

BlueCross BlueShield of Tennessee, Inc., un Licenciatario Independiente de BlueCross BlueShield Association.

ATTACHMENT A:
COVERED SERVICES AND LIMITATIONS ON COVERED SERVICES

The Plan will pay the TennCare*Select* Maximum Allowable Charge for Medically Necessary and Appropriate services and supplies described below and provided in accordance with the reimbursement schedules set forth in Attachment C: Schedule of Benefits of this Member Handbook. Charges in excess of the reimbursement rates set forth in the Schedule of Benefits are not eligible for reimbursement or payment.

To be eligible for reimbursement or payment, all services or supplies must be provided in accordance with Our Medical Policies and medical management procedures. (See Medical Policy and Medical Management Section.)

Covered Services and Limitations set forth in this Attachment are arranged according to:

- Eligible Providers, and
- Eligible services.

Network Providers have agreed not to bill You for the amount above the TennCareSelect Maximum Allowable Charge.

Out-of-Network Providers do not have a contract with Us. This means they will be able to charge You more than the amount set by Us in Our contracts. With Out-of-Network Providers, You will be responsible for the full amount that You are charged.

Obtaining services not listed in this Attachment or not in accordance with Our Medical Management Policies and Procedures may result in the denial of payment. Obtaining Prior Authorization is not a guarantee of Coverage. All provisions of the Member Handbook must be satisfied before Coverage for services will be rendered. Our Medical Policies can help Your Provider determine if a proposed service will be Covered.

Referrals are not required for specialty care.

Covered Services are limited to those in connection with Your pregnancy including complications of pregnancy as defined; and Prescription Drugs.

Please refer to Attachment C: Schedule of Benefits for these limits.

I. ELIGIBLE PROVIDERS OF SERVICE

A. Practitioners

All services must be rendered by a Practitioner listed in the Directory of Network Providers. The services provided by a Practitioner must be within his or her specialty or degree. All services must be rendered by the Practitioner, or the delegate actually billing for the Practitioner, and be within the scope of his or her licensure. Midwife services are eligible when performed in a facility.

B. Other Providers of Service

An individual or facility, other than a Practitioner, duly licensed to provide Covered Services and listed in the Directory of Network Providers.

C. Out-of-Network Providers

No benefits will be paid for services received from Out-of-Network Providers under this Plan. There are two exceptions to this:

1. You do have benefits for Out-of-Network, hospital-based Practitioners in a Network facility.
2. In a true Emergency, You have benefits for Out-of-Network Providers (Facility and Practitioners).

II. ELIGIBLE SERVICES:

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

A. Practitioner Office Services

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

1. Covered
   a. Office visits.
   b. Diagnostic laboratory and x-ray examinations.
   c. Injections and medications administered in a Practitioner's office, except Specialty Pharmacy Products. (See Provider Administered Specialty Pharmacy Products section for information on Coverage).
   d. Second opinions given by a Practitioner who is not in the same medical group as the Practitioner who rendered the initial diagnosis or initially recommended surgery. If an in-network Practitioner is not available to provide a second opinion, We will arrange for You to receive a second opinion from an out-of-network Practitioner at no more cost to you than if the second opinion had been obtained from an in-network Practitioner.
2. Exclusions
   a. Services and supplies not related to the pregnancy (pre and post natal care).

B. Inpatient Hospital Services

Medically Necessary and Appropriate services and supplies for pre and post natal care, including complications of pregnancy, performed in a Hospital which: (1) is a licensed Acute care institution; (2) which provides Inpatient services; (3) has surgical and medical facilities primarily for the diagnosis and treatment of a disease and injury; and (4) has a staff of

Physicians licensed to practice medicine and provides 24 hour nursing care by graduate registered nurses. Prior Authorization is required for any non-delivery hospital admission and observation stays.

1. Covered
    b. Room and board in a semi-private room (or private room if room and board charges are the same as for a semi-private room); general nursing care; medications, injections, diagnostic services and special care units.
    c. Attending Practitioner's services for professional care.
2. Exclusions
    a. Services and supplies not related to the pregnancy (pre and post natal care).
    b. Private room when not authorized by the Plan and room and board charges are in excess of semi-private room.

C. Hospital Emergency Care Services

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

1. Covered
    a. Medically Necessary and Appropriate Emergency services, supplies and medications necessary for the diagnosis and stabilization of Your Emergency condition.
    b. Practitioner services.

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

D. Ambulance Services

Medically Necessary and Appropriate land transportation, services, supplies and medications by a licensed ambulance service when time or technical expertise of the transportation is essential to reduce the probability of harm to You.

1. Covered
    a. Medically Necessary and Appropriate land or air transportation from the scene, services, supplies in connection with the pregnancy or complications of pregnancy.

2. Exclusions
    a. Transportation for Your convenience.
    b. Transportation that is not in connection with Your pregnancy.
    c. Services when You are not transported to a facility.

E. Outpatient Facility Services

Medically Necessary and Appropriate diagnostics, therapies and surgery performed in connection with the pregnancy or complications of pregnancy and occurring in an outpatient facility which includes: (1) outpatient surgery centers; (2) the outpatient center of a hospital; and (3) outpatient diagnostic centers.

1. Covered
    a. Practitioner services.
    b. Outpatient diagnostics (such as x-rays and laboratory services).
    c. Outpatient treatments (such as medications and injections).
    d. Outpatient surgery and supplies.
2. Exclusions
    a. Services and supplies not related to the pregnancy (pre and post natal care).

F. Diagnostic Services

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

1. Covered
    a. Non-routine Diagnostic Services ordered by a Practitioner.
    b. All other Diagnostic Services ordered by a Practitioner.
2. Exclusions
    a. Diagnostic Services which are not Medically Necessary and Appropriate or not in connection with pregnancy or complications of pregnancy.
    b. Diagnostic Services not ordered by a Practitioner.

G. Prescription Drug Program

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

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

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

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

a. You previously experienced an adverse reaction to the Generic Drug;

b. the Generic Drug has been demonstrated to be ineffective for You; or

c. any other clinically based need determined by the prescribing Provider.

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

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

1. Covered Services

   a. Prescription Drugs prescribed when You are not confined in a hospital or other facility. Prescription Drugs must be:

      (1) prescribed on or after Your Coverage begins;

      (2) approved for use by the Food and Drug Administration (FDA);

      (3) dispensed by a licensed pharmacist or Participating physician;

      (4) listed on the closed Drug Formulary; and

      (5) not available for purchase without a Prescription.

2. Limitations

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

   b. The Plan has time limits on how soon a Prescription can be refilled. If You request a refill too soon, the Network Pharmacy will advise You when Your Prescription benefit will Cover the refill.

c. Prescription and non-Prescription medical supplies, devices and appliances are not Covered, except for syringes or other supplies used in the treatment of diabetes;

d. Prescription Drugs which are commercially packaged or commonly dispensed in quantities less than a 30-calendar day supply (e.g. prescription items which are dispensed based on a certain quantity for a therapeutic regimen) will be subject to one Drug Copayment, provided the quantity does not exceed the FDA approved dosage for four calendar weeks.

e. The Plan does not Cover Prescription Drugs prescribed for purposes other than for:

   (1) indications approved by the FDA; or

   (2) off-label indications recognized through peer-reviewed medical literature.

f. Compound Drugs are only Covered when filled at a Network Pharmacy. The Network Pharmacy must submit the claim through the pharmacy benefit manager. The claim must contain a valid national drug code (NDC) number for at least one ingredient in the Compound Drug.

g. Smoking deterrents, such as patches, provided for assistance in smoking cessation. The following limitations apply to this benefit:

   (1) Prescription must be written by a licensed physician;

   (2) Prescriptions are for a 90-day period only; and

   (3) Benefit is allowable once per Plan year, with a maximum lifetime benefit of two 90-day periods.

3. Exclusions

The following services, supplies and Charges are not Covered under this section:

a. drugs which are prescribed, dispensed or intended for use while You are confined in a hospital, skilled nursing facility or similar facility, except as otherwise Covered in the Member Handbook;

b. any drugs, medications, Prescription devices or vitamins, available over-the-counter that do not require a Prescription by Federal or State law; and/or Prescription Drugs dispensed in a doctor’s office are excluded except as otherwise Covered in this Member Handbook;

c. any quantity of Prescription Drugs which exceed that specified by Our Plan’s P&T Committee; any Prescription Drug purchased outside the United States, except those authorized by Us;

d. any Prescription dispensed by or through a non-retail internet Pharmacy;

e. non-medical supplies or substances, including support garments, regardless of their intended use;

f. any drugs or medicines dispensed more than one year following the date of the Prescription;

g. Prescription Drugs You are entitled to receive without charge in accordance with any worker's compensation laws or any municipal, state, or federal program;

h. replacement Prescriptions resulting from lost, spilled, stolen, or misplaced medications (except as required by applicable law);

i. drugs dispensed by a Provider other than a Pharmacy;

j. administration or injection of any drugs;

k. Prescription Drugs not on the Drug Formulary;

l. 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;

m. DESI (Drug Efficiency Safety Implementation) and LTE (Less Than Effective) Drugs;

n. Experimental and/or Investigational Drugs;

o. Prescription Drugs obtained from an Out-of-Network Pharmacy;

p. Provider-administered Specialty Pharmacy Products, as indicated on Our Specialty Pharmacy Products list, except as otherwise Covered in this Member Handbook.

q. Prescription Drugs or refills dispensed:

    (1) in quantities in excess of amounts specified in the Benefit payment section; or

    (2) which exceed any applicable maximum benefit amounts stated in this Member Handbook.

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

BENEFITS FOR SELF-ADMINISTERED SPECIALTY PHARMACY PRODUCTS
There is a distinct 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 self-administered Specialty Pharmacy Products. Please refer to the Specialty Pharmacy Drug listing to determine which drugs may require Prior Authorization or have other limitations. (Please refer to the section on Provider Administered Specialty Pharmacy Products for Specialty Pharmacy products administered by a Provider.)
Specialty Pharmacy Products are limited to a 30-day supply per Prescription.

H. Newborn Care

Medically Necessary and Appropriate nursery and pediatric care of a healthy term newborn. Contact the HealthyTNBabies Eligibility Controller at 1-866-620-8864 to add your newborn to CoverKids or TennCare Medicaid.

1. Covered

   a. Nursery and routine pediatric care while mother confined to hospital.

   b. Circumcision.

   c. Physician charges for routine visits to newborn while confined and not requiring treatment.

2. Exclusions

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

I. Provider-Administered Specialty Pharmacy Products

Medically Necessary and Appropriate specialty pharmaceuticals related to the treatment of the pregnancy or complication of pregnancy, administered by a Practitioner or home health care agency. Please refer to the CoverKids/ HealthyTNBabies Prescription Drug Booklet at http://www.bcbst.com/pharmacy/cover-tn/. Review the "CoverKids Formulary" to determine which drugs may require Prior Authorization or have other limitations.

1. Covered

   a. Provider-administered Specialty Pharmacy Products as identified on the CoverKids HealthyTNBabies Specialty Pharmacy Products list (includes administration by a qualified provider).

2. Exclusions

   Self-administered Specialty Pharmacy Products as identified on the CoverKids HealthyTNBabies Specialty Pharmacy Product List. Self-administered Specialty Pharmacy Products are Covered in the Prescription Drug Program section of this Member Handbook.

ATTACHMENT B:
EXCLUSIONS FROM COVERAGE

HealthyTNBabies does not provide benefits for the following services, supplies or charges:

1. Services or supplies not listed as Covered Services under Attachment A, Covered Service.
2. Services or supplies that are determined to be not Medically Necessary and Appropriate or have not been authorized by the Plan.
3. Services or supplies that are Investigational in nature including, but not limited to: (1) drugs; (2) biologicals; (3) medications; (4) devices; and (5) treatments.
4. When more than one treatment alternative exists, each is Medically Appropriate and Medically Necessary, and each would meet Your needs, We reserve the right to provide payment for the least expensive Covered Service alternative.
5. Self treatment or training.
6. Staff consultations required by hospital or other facility rules.
7. Services which are free.
8. Personal, physical fitness, recreational or convenience items and services such as: (1) barber and beauty services; (2) television; (3) air conditioners; (4) humidifiers; (5) air filters; (6) heaters; (7) physical fitness equipment; (8) saunas; (9) whirlpools; (10) water purifiers; (11) swimming pools; (12) tanning beds, (13) weight loss programs; (14) physical fitness programs; (15) diapers; or (16) self-help devices which are not primarily medical in nature, even if ordered by a Practitioner.
9. Services or supplies received before Your effective date for Coverage with this Plan.
10. Services or supplies related to a Hospital Confinement, received before Your effective date for Coverage with this Plan.
11. Services or supplies received after Your Coverage under this Plan ceases for any reason. This is true even though the expenses relate to a condition that began while You were Covered.
12. Services or supplies received in a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union or similar group.
13. Telephone or email consultations or charges to complete a claim form or to provide medical records. Network Providers should not bill you for missed appointments nor are the charges for missed appointments Covered.
14. Services for providing requested medical information or completing forms. We will not charge You or Your legal representative for statutorily required copying charges.

15. Court ordered examinations and treatment, unless Medically Necessary.
16. Room, board and general nursing care rendered on the date of discharge, unless admission and discharge occur on the same day.
17. Charges in excess of the TennCareSelect Maximum Allowable Charge for Covered Services or any charges which exceed the individual benefit limits.
18. Any service stated in the Attachment A as a non-Covered Service or limitation.
19. Charges for services performed by You or Your spouse, or Your or Your spouse's parent, sister, brother or child.
20. Any charges for handling fees.
21. Safety items, or items to affect performance primarily in sports-related activities.
22. Services or supplies related to treatment of complications that are a direct or closely related result of a Member's refusal to accept treatment, medicines, or a course of treatment that a Provider has recommended or has been determined to be Medically Necessary, including leaving an inpatient medical facility against the advice of the treating physician.
23. Services or supplies for Maintenance Care.
24. Private duty nursing that would normally be provided by nursing staff, including private duty nursing care in a facility.
25. Pharmacogenetic testing.
26. Services or supplies to treat sexual dysfunction, regardless of cause, including but not limited to erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido.
27. Services or supplies for methadone maintenance therapy and buprenorphine maintenance therapy.
28. Provider-administered Specialty Pharmacy Products, except those specifically included in Attachment A, Covered Services.
29. Services for planned maternity delivery in a home setting or location other than a licensed Hospital or birthing center
30. Services, supplies and charges not related to the pregnancy or any complication of the pregnancy.
31. Services or supplies for Inmates confined in a local, state or federal prison or jail, or other penal correctional facility, including a furlough from such facility.
32. Services or supplies for the treatment of work related illness or injury, regardless of the presence or absence of workers' compensation coverage.
33. Services or supplies for sterilizations or the reversals of sterilizations.
34. Services or supplies for the treatment of illness or injury related to Your participation in a felony, attempted felony, riot or insurrection.

ATTACHMENT C: SCHEDULE OF BENEFITS

HEALTHYTNBABIES

GROUP I

To receive benefits from this Plan, make sure the Provider is a member of the Provider Network shown on the membership ID card. If You receive services from an Out-of-Network Provider, You will be responsible for the full payment of the Out-of-Network Provider's charge. **No Benefits are payable for services received from Out-of-Network Providers.**

Covered Services	**Copayment required for Covered Services received from Network Providers**
Services Received at the Practitioner's office	
Office Services for Pre and Post-natal care (including complications) The Copayment applies only to the initial visit for the Physician managing the pregnancy and delivery. The Copayment will apply to all other non-routine maternity related visits.	
Office Visits by a Primary Care Physician	$15 Copayment
Office Visits by a Specialist	$20 Copayment
Routine Diagnostic Services	No Copayment
Services Received at a Facility	
Inpatient Hospital Stays Prior Authorization is required for non-delivery admissions. Benefits will be denied for Network Providers outside Tennessee when Prior Authorization is not obtained. Network Providers in Tennessee are responsible for obtaining Prior Authorization. Member is not responsible for penalty when Tennessee Network Providers do not obtain Prior Authorization.	
Facility Charges Copayment waived if readmitted within 48 hours of initial visit for same episode	$100 Copayment per admission
Practitioner Charges (including Midwives)	No Copayment

Covered Services	Copayment required for Covered Services received from Network Providers
Hospital Emergency Care services	
Facility Charges (Copayment waived if admitted.): Emergency Condition (In-Network and Out-of-Network Provider) Non-emergency Condition (MUST be an In-Network Provider. If Out-of-Network Provider, benefits will not be paid.)	 $50 Copayment per visit $50 Copayment per visit
Practitioner charges	No Copayment
Urgent Care services	
Facility Charges: Emergency Room Walk-in Clinic	 $50 Copayment per visit $15 Copayment per visit
Practitioner charges	No Copayment
Outpatient Facility Services and Outpatient Surgery	
Facility Charges	$20 Copayment
Practitioner charges	No Copayment
Outpatient Diagnostic Services	
Routine and Non-Routine Diagnostic Services	No Copayment
Other Services	
Ambulance	No Copayment

<table>
<tr><th colspan="2">Covered Services</th><th colspan="2">Copayment required for Covered Services received from Network Providers</th></tr>
<tr><td colspan="4">Services Received at the Pharmacy</td></tr>
<tr><td colspan="4">Prescription Drugs
Retail up to 30 day supply. Up to 90 day supply for one copayment through home delivery and certain retail pharmacies. If You choose a Brand Name Drug (Preferred or Non-preferred) when a Generic Drug equivalent is available, You will be financially responsible for the amount by which the cost of the Brand Name Drug exceeds the Generic Drug cost plus the required Generic Drug Copayment. Some Specialty Pharmacy Products require Prior Authorization. Please refer to the Specialty Pharmacy Drug Listing for a list of Specialty Pharmacy products requiring Prior Authorization.</td></tr>
<tr><td colspan="2">Generic</td><td colspan="2">$5 Copayment</td></tr>
<tr><td colspan="2">Preferred Brand</td><td colspan="2">$20 Copayment</td></tr>
<tr><td colspan="2">Non-Preferred Brand</td><td colspan="2">$40 Copayment</td></tr>
<tr><td>Specialty Pharmacy Drugs</td><td colspan="2">Copayment required when purchased at Specialty Pharmacy</td><td>Copayment required when purchased at Network Pharmacy</td></tr>
<tr><td>Generic</td><td colspan="2">$5 Copayment</td><td>$5 Copayment</td></tr>
<tr><td>Preferred Brand</td><td colspan="2">$20 Copayment</td><td>$20 Copayment</td></tr>
<tr><td>Non-Preferred Brand</td><td colspan="2">$40 Copayment</td><td>$40 Copayment</td></tr>
<tr><td colspan="2">Miscellaneous Limits</td><td colspan="2">Maximum</td></tr>
<tr><td colspan="2">Maximum Out of Pocket for all Services</td><td colspan="2">5% of Family Income</td></tr>
</table>

WE DO NOT ALLOW UNFAIR TREATMENT IN COVERKIDS/HEALTHYTNBABIES.

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

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

BlueCross BlueShield of Tennessee, Inc., an Independent
Licensee of the BlueCross BlueShield Association

HTNB-5 (7/15)
HeathyTNBabies Member Handbook Group I