

STATE OF TENNESSEE

2027 Member Handbook

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

of Tennessee

PARTNERS FOR HEALTH

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Welcome

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

Thank you for choosing BlueCross. We've been working in Tennessee for 80 years to provide quality, affordable healthcare. Today, more than 3 million people nationwide turn to us for healthcare coverage.

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

BlueCross BlueShield of Tennessee
Member Service: 800-558-6213
7 a.m. to 5 p.m. CT M-F

Member ID Cards

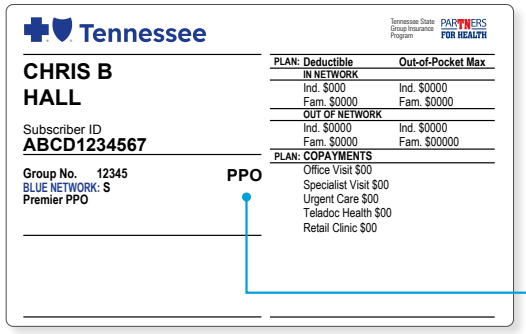
You have ID cards for yourself and each of your covered dependents. All cards list your name as the employee or head of contract. The cards show your health plan and network. Your network is either **Blue Network S℠** or **Blue Network P℠**. Review this information carefully and call if you have any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

See your actual Member ID card.

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

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

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



Front

Annual deductible and out-of-pocket maximum amounts

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

PPO means your plan covers you throughout the U.S. and many countries.

Prior authorization instructions



Back

Member Service phone number

The number to call if you're outside Tennessee

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

Other important numbers

Where's my Member ID card?

- You can continue using the card(s) you used in 2026. You will only receive new card(s) if you are enrolled in the CDHP for state and higher education, you change your medical coverage or make other changes that require a change to your ID card(s).
- You can use a digital version of your card by logging in to the **BCBSTN℠** app.
- You can print temporary cards or request physical cards by logging in to your account at **bcbst.com/tn_state**.



BlueCross BlueShield of Tennessee Contact Information

BlueCross BlueShield of Tennessee
Member Support: 800-558-6213
7 a.m. to 5 p.m. CT M–F

Report Fraud: 888-343-4221
Transplant Coordinator: 888-207-2421

Find in-network providers while traveling:

- For U.S. providers log in to your account at **bcbst.com/findaprovider** and set your city, state or ZIP.
- For providers outside the U.S., call **800-810-BLUE (2583)** toll-free or **804-673-1177** collect, or visit **bcbsglobalcore.com**.

Mailing address for claims:

BlueCross BlueShield of Tennessee
Claims Service Center
1 Cameron Hill Circle Ste. 0002
Chattanooga, TN 37402-0002

Mailing address for pre-determination requests:

BlueCross BlueShield of Tennessee
Predeterminations/ODM, 2G
1 Cameron Hill Circle Ste . 0014
Chattanooga, TN 37402-0014

Mailing address for Unique Care, Transition of Care and Continuity of Care exception requests:

BlueCross BlueShield of Tennessee
State Unique Care/Continuous Care
1 Cameron Hill Circle
Chattanooga, TN 37402

Other Benefits

You have access to other benefits because you're enrolled in medical insurance with Partners for Health. For example:

- Behavioral health savings when you use preferred alcohol and drug use treatment facilities
- Wellness program support for weight loss and diabetes prevention
- Centers of Excellence for surgeries and cancer care
- Pharmacy savings on 90-day supplies of certain maintenance medications

BlueCross does not manage these other benefits. Use the phone numbers and links on this page to learn more about them.

Behavioral Health, Substance Use and Emotional Wellbeing Solutions

Optum Behavioral Health
855-Here4TN
(855-437-3486)
Here4TN.com

Centers of Excellence Services

Carrum Health
888-855-7806
Carrum Health website

Important Notice About Weight-loss Surgery Benefits:

In 2027, weight-loss surgery will only be covered through the **Carrum Health centers of excellence program.** There will be no cost share for PPO members and no cost for CDHP members after meeting their deductible. Weight-loss surgery performed by any other provider will not be covered.

Flexible Spending Accounts and Health Savings Accounts

TASC
800-575-6277
www.stateoftntasc.com

Pharmacy

CVS Caremark
877-522-TNRX (8679) | 24/7
info.caremark.com/stateoftn

Sharecare Wellness Program

Sharecare
888-741-3390
Monday – Friday 8 a.m. – 8 p.m. CT



Medical Plan Highlights

In-Network Preventive Care

There's no member cost share for in-network preventive care. This means you don't pay any copay, deductible or coinsurance.

Personalized virtual exercise therapy program and support for back, joint and muscle pain from Hinge Health. Get relief without leaving the comfort of your home at no additional cost. Call **855-902-2777**.

BCBS Blue Distinction® Center of Excellence Transplant Facilities

Save on approved transplants at preferred transplant facilities. There's no member cost share for PPO plan members and only a deductible for CDHP members. See details on page 16 of this handbook.

Expert medical opinion for diagnosis and treatment from Teladoc® Health. Visit **teladochealth.com/benefits/stateoftenn** or call **800-835-2362**.

Provider-administered specialty medications outreach

Some medications for chronic, serious diseases such as hepatitis C and arthritis are given to you in an office or outpatient setting. Your doctor will take care of approvals and order these medications for you. If you get a call from a pharmacy or your doctor's office, it's important that you provide what is asked of you. This will allow the order for your medication to be filled without delay. You'll pay your usual cost share (copay or deductible and coinsurance) for your medication, and your provider will give it to you. This outreach will not result in any change to pharmacy benefits administered by CVS Caremark.

Specialty medications through your pharmacy benefit

You have a separate out-of-pocket maximum. CVS Caremark will keep track of eligible expenses you pay toward this annual limit, including any specialty pharmacy deductibles.

Your eligible expenses for medical care, behavioral health services and non-specialty prescriptions will continue to count toward your regular in-network and out-of-network out-of-pocket maximums, which are tracked by BlueCross BlueShield of Tennessee.

The New Copay PPO Plan

Local education and local government members enrolled in this medical plan option have:

- New medical, behavioral health and pharmacy ID cards
- Network S providers
- Predictable copay costs and no deductibles for in-network benefits
- Coinsurance for weight-loss and specialty drugs
- CVS Value Formulary for prescription drugs
- Out-of-pocket maximums



TIP: Local education and local government members – Find Copay PPO details on the **Health webpage** of the Partners for Health website. You can also watch a **video** to learn more.

Important Reminders

This handbook covers ALL medical plans offered through Partners for Health:

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

Benefit grids and cost comparisons for ALL medical plans are on the Partners for Health website, tn.gov/partnersforhealth.

Follow the prompts below:

- Publications – **Insurance Comparison Charts** 2027 Comparison Charts
- Publications – **Medical Plan Documents** - 2027
- Important – Summary of Benefits – **Summary of Benefits and Coverage** - 2027 Summaries

Your Member ID card includes your plan name, common costs, network and important phone numbers.

Know your plan name and pay close attention when it appears in this handbook. Some details, including costs, vary by plan.

Your health coverage is effective Jan. 1 through Dec. 31, 2027, based on eligibility. You can't change plans or networks during the year unless you have a qualifying event. A provider or hospital leaving a network is not a qualifying event.

Be careful when signing medical waivers. Doing so could make you responsible for unpaid charges.

You have protections against surprise medical bills when you receive emergency care or see an out of network provider at an in network facility. Learn more at: **tn.gov/Partnersforhealth/no-surprises-act-transparency-in-coverage.html**.

Need help with a bill?

If you receive an unexpected medical bill, call BlueCross BlueShield of Tennessee Member Service at **800-558-6213**. Have your Explanation of Benefits and provider bill ready. You can view your EOB by signing in at **bcbst.com/tn_state**.

You can choose how you get notifications from BlueCross. Let us know what you prefer – through the BCBSTN app, by text or by email.

Share your feedback with us and help improve services by joining BlueVoice at **bcbst.com/BlueVoiceTN**.

Provider-Administered Specialty Medications

Call **800-558-6213** for details. Your doctor handles approvals and ordering. You may hear from a pharmacy vendor or your provider's office if more information is needed. Respond quickly to help avoid delays. You'll pay your usual cost share, and your provider will administer your medication. This program does not change pharmacy benefits managed by CVS Caremark. Some specialty medications for chronic or serious conditions (such as hepatitis C or arthritis) are administered in an office or outpatient setting.

Benefits Administration prohibits discrimination based on race, color, national origin, sex, age or disability. To report a concern, call **615-532-9616**.

Your Insurance Benefits Package – Medical and More

BlueCross BlueShield of Tennessee administers your medical coverage, and this handbook explains that coverage. BlueCross is not responsible for processing claims for pharmacy or behavioral health benefits. This page gives basic details about your plan and other benefits. Save or bookmark it so you can quickly find more information and get the help you need from the correct people.

Your Partners for Health Plan

Your insurance benefits are managed by Benefits Administration, a division of the Department of Finance and Administration, on behalf of the State Group Insurance Program.

Your Monthly Medical Premium

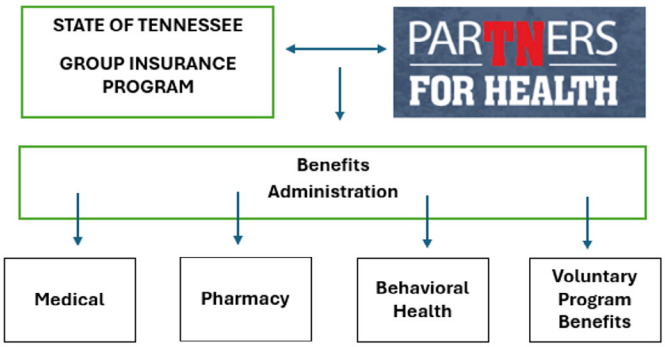
The monthly premium you pay for medical benefits also covers pharmacy benefits, behavioral health services and a wellness program.

Your Insurance Cards

You have three separate ID cards for medical, behavioral health and pharmacy benefits. The back of each card has a specific customer service number. Using the correct card and calling the number on that card will improve your customer service experience.

Voluntary Benefit Programs

Partners for Health voluntary benefits—like dental, vision and other programs—aren't included in your medical plan. You pay separate premiums for these benefits.



Find All the Details and Get Help:

- **Pharmacy – CVS Caremark**
  877-522-TNRX (8679) | 24/7
  info.caremark.com/stateoftn

- **Behavioral Health Services - Optum Behavioral Health**
  Behavioral Health, Substance Use and Employee Assistance Program
  855-HERE4TN (855-437-3486) | 24/7
  HERE4TN.com

- **Voluntary Benefit Programs**
  Visit the Partners for Health Website And look under "Other Benefits"

- **Partners For Health website**
  https://www.tn.gov/partnersforhealth.html

TIP: If you have questions about eligibility or enrollment - like adding dependents, when coverage starts or ends, or how to change or end your coverage - contact the benefits coordinator at your agency. They work closely with Benefits Administration and can help you get the answers you need. You can also reach Benefits Administration directly. Call **800-253-9981** or **615-741-3590** Monday - Friday, 8 a.m. - 4:30 p.m. CT or email **benefits.administration@tn.gov.**

of Tennessee

PARTNERS FOR HEALTH

Resources To Help You Navigate Your Insurance Benefits

BlueCross BlueShield of Tennessee

800-558-6213
Monday - Friday, 7 a.m. - 5 p.m. CT
bcbst.com/members/tn_state/

Your Member Website

Find everything you need to make the most of your health plan. Explore tools, plan details and helpful extras like Identity Protection, Member Discounts, Hinge Health and Teladoc Health for general care, urgent care and second-opinion services.

Your Secure Member Portal

Log in with your username and password to access your personal plan details. View your ID numbers, claims, costs, balances, forms and ID card. You can even chat with BlueCross.

More For You

See the back cover of this handbook to learn more about your BCBSTN mobile app and a new video that will make using your online and mobile resources easier than ever.

TIP: When you're online, look for symbols like the ones shown below. They'll help you get support, ask questions or start a chat.

Partners for Health | Benefits Administration

800-253-9981 or **615-741-3590**
Monday - Friday, 8 a.m. - 4:30 p.m. CT
benefits.administration@tn.gov

Our mission is to deliver comprehensive, affordable, dependable and sustainable benefits.

Your One-Stop Insurance Benefits Shop

Explore the tabs at the top of the Partners for Health website to quickly find what you need. Here's a snapshot of what you can browse:

- **Health Options –** carrier details, CDHP/HSA, pharmacy, behavioral health and included benefit extras*
- **Other Benefits –** Dental, Vision, Life, Disability, Flexible Benefits, Wellness, Employee Assistance Program, The Tennessee Plan and Working for a Healthier Tennessee
- **Publications –** Plan comparison charts, provider directories, plan documents, benefit handbooks, certificates of coverage and forms
- **Premiums, Videos and Contact Information**

* **Learn more about the value of your health plan on the Included Benefits Extras webpage** Telehealth, Center of Excellence Services, Personalized Exercise Therapy, Diabetes Prevention Program, Expert Medical Opinion Services, Behavioral Telehealth, Substance Use Waived Treatment Costs, Fitness Center Discounts and More Ways to Save Money.

Cost Sharing

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

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

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

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

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

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

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

There are in-network and out-of-network deductibles for all plans **except the Copay PPO**, which only has an out-of-network deductible. The two deductibles add up separately. In-network charges cannot be applied to an out-of-network deductible, and out-of-network charges cannot be applied to an in-network deductible.

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

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

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

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

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

2027 Health Plan Comparisons show your copayments, coinsurance, deductibles and your out-of-pocket maximum amounts. You can find them on the **Publications page of the Partners for Health website**. Be sure you choose the link for the comparison that fits your employer group - either **State and Higher Education** OR **Local Education and Local Government**. Then, focus on the columns specific to the plan you have.

Understanding Your Out-of-Pocket Maximums

Your plan has different out-of-pocket maximums depending on the type of care you receive. Here's how it works:

- **Specialty drugs (through your pharmacy benefits)** count toward your specialty pharmacy out-of-pocket maximum. CVS Caremark will keep track of eligible expenses you pay toward this annual limit, including any specialty pharmacy deductibles. If you have questions about specialty drugs contact CVS Caremark.
- **Medical care, behavioral health and non-specialty prescriptions** count toward your other out-of-pocket maximums, based on whether you use in-network or out-of-network providers. These amounts are tracked by BlueCross BlueShield.
- **Deductibles also count** and those go toward the maximum for the category of the service received.
- **What doesn't count?** Ineligible expenses, including charges above the allowed amount and services not covered by your plan.

PPO Plans

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

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

- In-network preventive care (annual well visit and routine screenings) is covered at no cost to you.
- You pay copays for other covered services like:
  - Office visits to primary care providers and specialists
  - Behavioral health and substance use services
  - Telehealth
  - Visits to convenience clinics
  - Urgent care facilities, and
  - Most prescription medications

You pay deductible and coinsurance for things like:

- Emergency rooms
- Ambulance services
- Inpatient hospital care
- Outpatient surgery
- Advanced imaging, and
- Durable medical equipment

If you're enrolled in the **Copay PPO** plan:

- In-network preventive care (annual well visit and routine screenings) is covered at no cost to you.
- You'll pay copays for in-network medical services.
- You'll pay coinsurance for 30-day supplies of specialty pharmacy medications and medications prescribed for obesity.
- You'll pay a deductible and coinsurance for most out-of-network care.

Consumer-driven Health Plans

A CDHP includes a tax-free health savings account, which you own and can use to pay for qualified medical expenses. Qualified expenses may include things that may not be covered by your health insurance plan, like vision and dental expenses, hearing aids, contact lens supplies and more.

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

- In-network preventive care (annual well visit and routine screenings) is covered at no cost to you.
- You pay coinsurance for ALL other covered services.
- You must meet your deductible before the plan pays for covered expenses, EXCEPT for in-network preventive care and 90-day supply maintenance medications.



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

Engaging in Your Healthcare

Blue Distinction Specialty Care®

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

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

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

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

- Bariatric surgeries are only covered through the Carrum Health centers of excellence program despite the facilities listed on the site.
- Coverage for family planning services is limited in the Partners for Health Plans. Check your coverage policy prior to seeking care.

Quality and Safety in Healthcare

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

Quality and safety vary widely in healthcare.

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

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

Covered Medical Expenses

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

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

Medical Benefit Reminders

- **In-Network Preventive Care –** There is no charge to you, but you will be responsible for your share of the cost if your provider bills for something other than preventive care. You will also have a cost if you receive care out-of-network.
- **Emergency Room Services –** Cost sharing for all plan options is deductible and coinsurance EXCEPT for the Copay PPO which is copay only.
- **Provider Search for Copay PPO –** If your plan is the Copay PPO, you will use only BlueCross BlueShield Network S providers. You can choose between Tier 1 and Tier 2 providers for primary care office visits, specialist office visits, office surgery and visits for allergy injections and serum. You will pay less when you choose providers in Tier 1. Search the **BlueCross Tiered Network S directory** for your providers and learn if they are in Tier 1 or Tier 2.
- **If you have scheduled a visit for a colonoscopy or a mammogram,** it is very important that you talk to your healthcare provider about the type of service you will have. There is no charge for in-network preventive services. However, you may be charged for services scheduled for diagnostic purposes or billed as anything other than preventive care. You will not be responsible for costs if applicable law states that cost sharing requirements cannot be imposed.
- **Ask early if you don't know.** If you are unsure about whether a procedure, type of facility, equipment or any other expense is covered, ask your physician to submit a pre-determination request form to BlueCross describing the condition and planned treatment. Pre-determination requests may take up to three weeks to review.

Excluded Services and Procedures

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

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



How the Plan Works

Choice of Doctors

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

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

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

You may sometimes need to see a specialist for a medical condition. Simply choose an in-network specialist and schedule an appointment.

If an in-network provider determines you should be admitted to the hospital or need services that require prior authorization, they will handle these plan requirements for you. However, it´s a good idea for you to contact BlueCross to confirm your benefits for hospital admissions or other services that require prior authorization.

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

Telehealth

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

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

For the Copay PPO, you pay $0 per telehealth visit.
For other PPO plans, you pay $15 per telehealth visit.
For CDHP/HSA plans, you pay the negotiated rate until you reach your deductible, then your primary care office coinsurance applies.

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

Learn more and schedule your appointment today. Log in to **bcbst.com** and choose **Talk With a Doctor Now** to get started, or use the **BCBSTN** app.

Yearly Benefits

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

Maternity Benefits

Coverage for maternity benefits involves an initial office visit cost to verify the pregnancy. Routine prenatal care is covered as preventive care. Labor and delivery charges will follow inpatient hospital benefit cost share. Should complications arise that require additional services of a specialist, additional charges will apply.

Hospice Benefits

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

Plan	Coverage
Copay PPO	100% covered
Premier PPO	100% covered
Standard PPO	100% covered
Limited PPO	100% covered
CDHP/HSA	100% covered after deductible
Local CDHP/HSA	100% covered after deductible

Dental Treatment

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

Member Costs by Plan:

All benefits are after plan deductible except for in-network Copay PPO.

Plan	Oral Surgeons		Non-Contracted Providers (i.e., dentists, orthodontists)
	In-Network	Out-of-Network	
Premier PPO	15%	40%	15%
Standard PPO	20%	40%	20%
Limited PPO	30%	50%	30%
CDHP/HSA	20%	40%	20%
Local CDHP/HSA	30%	50%	30%
Copay PPO	Specialist office: $50 Tier 1 / $100 Tier 2 Ambulatory Surgical Center: $1,000 Outpatient Hospital: $2,500	50%	Specialist office: $50 Tier 1 / $100 Tier 2 Ambulatory Surgical Center: $1,000 Outpatient Hospital: $2,500

Transplant Benefits

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

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

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

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

Plan	Cost Savings	Usual In-Network Member Share
Copay PPO	100% covered	$2500 inpatient copay
Premier PPO	100% covered	Deductible plus 15% coinsurance
Standard PPO	100% covered	Deductible plus 20% coinsurance
Limited PPO	100% covered	Deductible plus 30% coinsurance
CDHP/HSA	100% covered after deductible	Deductible plus 20% coinsurance
Local CDHP/ HSA	100% covered after deductible	Deductible plus 30% coinsurance

Benefits: In-Network or Out-of-Network

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

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

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

Maximum Allowable Charge Defined

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

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

Convenient Care and Urgent Care

Members sometimes have a need for medical care during evenings or on weekends. Convenient care and urgent care are options for health conditions that are important, but don't result from a life-threatening condition. You can search for a provider online or refer to a provider directory to find in-network facilities.

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

Urgent care centers treat more serious injuries or illnesses, like urinary tract infections, broken bones or deep cuts that may require X-rays or more complicated lab tests. They are often near a hospital but can also be free standing.

Your Rights and Protections Against Surprise Medical Bills

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

Emergency Care

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

The emergency room should be used only in the case of an emergency or for urgent care as directed by your doctor. The highest level of benefits is available for any emergency room visit that meets the definition of an emergency explained below.

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

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

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

If you receive a bill for emergency services asking you to pay more than you expected to pay, call BlueCross Member Service. Be prepared to provide a copy of the bill you received, and ask for a review of your claim to see if insurance can pay anything more. Also, see the "Your Rights and Protections Against Surprise Medical Bills" section of this handbook.

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

Out-of-Network Providers at In-Network Facilities

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

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

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

Utilization Management

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

- Pre-admission certification
- Post-certification of emergency admissions
- Certain outpatient procedures
- Home healthcare
- Case management
- Durable medical equipment
- Provider Administered Specialty Pharmacy program

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

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

Prior Authorization

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

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

- Inpatient hospital services
- Skilled nursing facility stays
- Home healthcare
- In-patient hospice
- Home infusion therapy (certain drugs)
- Advanced X-rays, scans and imaging
- Durable medical equipment (certain equipment greater than $1,000)
- Chemotherapy and radiation therapies
- Provider-administered specialty medications (administered in provider offices, inpatient and outpatient hospitals, infusion centers, home health, etc. and not at a pharmacy)
- Non-emergent ambulance transport (air and ground)
- Certain musculoskeletal procedures including, but not limited to, spinal surgeries, spinal injections and hip, knee and shoulder surgeries
- Neonatal ICU
- Advanced therapeutics used to treat or cure genetic conditions
- Transplants
- Genetic testing – certain outpatient genomic and molecular testing
- Endometrial ablation
- Blepharoplasty/browplasty
- Breast surgery for augmentation or reduction
- Hyperbaric treatments
- Panniculectomy
- Hearing aids

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

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

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

PA is not required for maternity admissions or emergency care.

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

Hospitalization

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

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

Advanced Radiological Imaging

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

Durable Medical Equipment

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

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

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

Coordination of Benefits With Other Insurance Plans

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

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

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

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

Coordination of benefits will be applied to your claims so that:

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

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

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

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

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

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

Claims Subrogation

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

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

Benefit Level Exceptions

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

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

Unique Care

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

If a unique care exception is granted, benefits are paid at the in-network level. Reasonable charges for transportation may also be covered, as detailed in the medical plan documents on the Partners for Health website.

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

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



Transition of Care

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

Continuity of Care

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

Expert Medical Opinion

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

Teladoc Health can help you get a virtual second opinion from top specialists for your condition or treatment at no additional cost to you.

When you should consider a second opinion:

- You've seen little improvement in your current treatment plan
- You have questions about test results
- You're considering a major surgery
- You want recommendations on alternative treatments or modified diagnoses

Register for Teladoc Health online at **TeladocHealth.com** with the company code **BCBST State of TN**.

You can also call **800-835-2362** Monday through Friday from 8:30 a.m. to 11 p.m. ET.

Care Management

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

Filing Claims

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

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

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

BlueCross is not responsible for processing claims for pharmacy or behavioral health and substance use treatment. Contact information for those programs is provided on page 5 under the **"Other Benefits"** section of this handbook.

Out-of-State Providers

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

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

Out-of-Country Care

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

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

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

1. Always carry your BlueCross BlueShield of Tennessee identification card.
2. Check with Member Service at **800-558-6213** before leaving the U.S.
3. If you need emergency medical care, go to the nearest hospital. Call the BlueCross BlueShield Global Core℠ Service Center at **800-810 BLUE (2583)** or call collect at **804-673-1167** if you are admitted.
4. If you need non-emergency medical care, you must call the BlueCross BlueShield Global Core Service Center. The service center will facilitate hospitalization at a BlueCross BlueShield Global Core hospital or make an appointment with a doctor. It is important that you call the BlueCross BlueShield Global Core Service Center in order to get cashless access for inpatient care. The service center is staffed with multilingual representatives and is available 24 hours a day, seven days a week.

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

Out-of-network benefits only;
out-of-network deductible applies

Plan	Coinsurance
Copay PPO	50%
Premier PPO	40%
Standard PPO	40%
Limited PPO	50%
CDHP/HSA	40%
Local CDHP/HSA	50%

Member Discount Program

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

You can save on:

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

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

Tobacco Cessation Products

Members who want to stop using tobacco products can get free **tobacco quit aids**.

Vaccinations

Partners for Health makes available to all plan members a comprehensive vaccination benefit that is free of charge.

To use this benefit, members can:

- Visit a pharmacy in the CVS Caremark Vaccine Pharmacy network and present their Caremark ID card to the pharmacist for their recommended vaccinations and pay $0 copay. To check which pharmacies are in-network for vaccinations, use the online Pharmacy Locator tool: **info.caremark.com/stateoftn** and select **"Search for a Network Pharmacy"**. Enter your zip code and then select **"Sort and refine"**, then select **"Vaccine Network"** and **"Apply".**
- Visit their regular in-network physician and present their medical ID card to receive their recommended vaccinations free of charge as well.

Diabetic Supplies

The preferred covered meters, test strips and supplies are those from Accu-Check and True Metrix. You will have a lower member cost share using supplies from these preferred brands. Diabetic supplies can be filled under the pharmacy benefit with CVS Caremark.



Member Rights and Responsibilities

Member Rights

You have the right to:

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

Member Responsibilities

Members are responsible for:

- Reading the member materials in their entirety and complying with the rules and limitations as stated.
- Contacting in-network providers to arrange for medical appointments as necessary.
- Notifying providers in a timely manner of any cancellations of appointments.
- Paying the cost sharing as stated in the benefit plan documents at the time service is provided.

- Receiving prior authorization for services when required, and complying with the limits of the prior authorization.
- Carrying and using their plan identification card and identifying themselves as a plan member prior to receiving medical services.
- Using in-network providers consistent with the applicable benefit plan.
- Providing, to the extent possible, information needed by professional staff in order to care for the member.
- Following instructions and guidelines given by those providing healthcare services.

Confidentiality and Privacy

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

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

Important steps are taken to protect your privacy.

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

Members have the right to approve the release of personal health information in special circumstances beyond those listed above.

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

Women's Health and Cancer Rights Act

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

Services Covered by the Barry Brady Act

If you are a firefighter who qualifies for additional health screenings under the Barry Brady Act and your related claims process with unexpected member cost share, call BlueCross Member Service and request a reconsideration of your claims. This coverage will be provided in consultation with the attending physician and patient. Benefits are subject to the same cost sharing as other services.

Appeals

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

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

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

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

Call First

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

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

Medical Services or Payment Issues – call BlueCross at **800-558-6213**.

Other Benefits - Phone numbers for behavioral health and substance use and pharmacy can be found on page 5 under the **'Other Benefits'** section of this handbook**.**

Deadline To File Appeals

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

Enrollment and Premium Appeals

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

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

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

Medical Service Appeals

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

First Internal Appeal – If the issue cannot be resolved through Member Service, you may file an appeal/member grievance.

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

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

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

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

Expedited Reconsideration – If a denial of coverage or authorization can reasonably be expected to prevent a covered individual from obtaining urgently needed

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

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

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

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

BlueCross BlueShield of Tennessee (BlueCross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex[1]. BlueCross does not exclude people or treat them less favorably because of race, color, national origin, age, disability or sex.

BlueCross:

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

If you need these reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact a consumer advisor at the number on the back of your Member ID card or call 800-565-9140 (TTY: 800-848-0298 or 711).

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

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

You can contact BlueCross's Nondiscrimination Coordinator at 423-535-1010 (TTY: 800-848-0298 or 711); Nondiscrimination_CoordinatorGM@bcbst.com (email); or Corporate Compliance, 1 Cameron Hill Circle, 1.4, Chattanooga, TN 37402.

This notice is available at BlueCross's website: bcbst.com.

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

[1] Consistent with the scope of sex discrimination described at 45 CFR 92.101(a)(2))

ATTENTION: If you speak English, free language assistance services and appropriate auxiliary aids and services are available to you. Please call the Member Service number on the back of your Member ID card or 800-565-9140 (TTY: 800-848-0298).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma, así como ayudas y servicios auxiliares adecuados. Llame al número de Servicio de atención a miembros que figura en el reverso de su tarjeta de identificación de miembro o al 800-565-9140 (TTY: 800-848-0298).

انتباه: إذا كنت تتحدث العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية والخدمات والأدوات المساعدة المناسبة. يُرجى الاتصال برقم خدمة الأعضاء الموجود على ظهر بطاقة هوية العضو الخاص بك أو بالرقم 800-565-9140 (الهاتف النصي: 800-848-0298)

注意：如果您說中文，我們提供免費的語言協助服務，以及適當的輔助協助和服務。請撥打會員 ID 卡背面的會員服務部號碼或 800-565-9140（聽障專線 (TTY)： 800-848-0298）。

LƯU Ý: Nếu quý vị nói tiếng Việt, quý vị sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí và các dịch vụ và công cụ hỗ trợ phù hợp. Vui lòng gọi đến số của bộ phận Dịch vụ Hội viên ở mặt sau Thẻ ID Thành viên của quý vị hoặc số 800-565-9140 (TTY: 800-848-0298).

주의: [한국어]를 사용하시는 경우, 무료 언어 지원 서비스 및 적절한 보조 기구와 서비스가 제공됩니다. 가입자 ID 카드 뒷면의 가입자 서비스 전화번호 또는 800-565-9140(TTY: 800-848-0298)번으로 전화하시기 바랍니다.

ATTENTION : Si vous parlez français, des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés sont à votre disposition. Veuillez appeler le numéro du Service adhérents indiqué au dos de votre carte d'assuré adhérent ou le 800-565-9140 (TTY/ATS : 800-848-0298).

เอົาใจໃส่: ຖ້າທ່ານເວົ້າພາສາ ພາສາລາວ, ມີການບໍລິການ ຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການທີ່ ເໝາະສົມໃຫ້ທ່ານ. ກະລຸນາໂທຫາເບີຂອງຝ່າຍບໍລິການສະມາຊິກ ທີ່ມີຢູ່ດ້ານຫຼັງບັດ ID ສະມາຊິກຂອງທ່ານ ຫຼື 800-565-9140 (TTY: 800-848-0298).

ማስገንዘቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ረዳት መርጃዎች እና አገልግሎቶች ለእርስዎ ይገኛሉ። በአባልነት መታወቂያዎ ጀርባ ላይ በሚገኘው የአባላት አገልግሎት ቁጥር ወይም በ 800-565-9140 (TTY: 800-848-0298) ይደውሉ።

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste und geeignete Hilfsmittel und Dienstleistungen zur Verfügung. Bitte rufen Sie die Nummer des Mitgliederdienstes auf der Rückseite Ihrer Mitglieds-ID-Karte oder 800-565-9140 (TTY: 800-848-0298) an.

ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારા માટે નિ:શુલ્ક ભાષા સહાય સેવાઓ અને યોગ્ય સહાયક સાધનો અને સેવાઓ ઉપલબ્ધ છે. કૃપા કરીને તમારા સભ્ય ID કાર્ડની પાછળના સભ્ય સર્વિસ નંબર ઉપર અથવા 800-565-9140 (TTY: 800-848-0298) પર કૉલ કરો.

お知らせ：日本語をお話しになる場合は、無料の支援サービスと適切な補助器具・サービスがご利用いただけます。会員IDカードの裏面に記載の会員サービス番号あるいは 800-565-9140 (TTY: 800-848-0298)まで、お電話にてご連絡ください。

PANSININ: Kung kayo ay nagsasalita ng Tagalog, magagamit para sa inyo ang libreng mga serbisyong tulong sa wika at kaukulang mga karagdagang tulong at mga serbisyo. Mangyaring tawagan ang numero ng Serbisyo sa Miyembro na nasa likod ng inyong Kard ng ID ng Miyembro o sa 800-565-9140 (TTY: 800-848-0298).

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए नि:शुल्क भाषा सहायता सेवाएँ और उपयुक्त सहायक साधन और सेवाएँ उपलब्ध हैं। कृपया अपने सदस्य ID कार्ड के पीछे दिए गए सदस्य सेवा नंबर या 800-565-9140 (TTY: 800-848-0298) पर कॉल करें।

ВНИМАНИЕ! Если Вы говорите по-русски, Вам будут предоставлены услуги языковой поддержки и соответствующие вспомогательные средства и сервисы на бесплатной основе. Позвоните в отдел обслуживания участников по номеру, указанному на обратной стороне Вашей идентификационной карты участника, или по номеру 800-565-9140 (TTY: 800-848-0298).

توجه: اگر به زبان فارسی صحبت می کنید، خدمات کمک زبانی رایگان و مساعدت ها و خدمات کمکی مناسب در دسترس شما هستند. درصورتیکه عضو هستید، با شماره خدمات اعضا در پشت کارت عضویت خود یا 800-565-9140 (TTY: 800-848-0298) تماس بگیرید.

ATANSYON: Si w pale Kreyòl Ayisyen, genyen sèvis asistans gratis pou lang ansanm ak èd pou sèvis oksilyè apwopriye k ap disponib pou ou. Tanpri rele nimewo Sèvis Manm ki sou do kat ID Manm ou an oswa 800-565-9140 (TTY: 800-848-0298).

UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej oraz rozwiązań i usług pomocniczych. Prosimy zadzwonić pod numer działu obsługi ubezpieczonych podany na odwrocie karty identyfikacyjnej członka lub numer 800-565-9140 (TTY: 800-848-0298).

ATENÇÃO: Se você fala Português, serviços gratuitos de assistência linguística e recursos e serviços auxiliares apropriados estão disponíveis para você. Ligue para o número de telefone do serviço de Atendimento ao Membro informado no verso de seu cartão de identificação de membro ou para 800-565-9140 (TTY: 800-848-0298).

ATTENZIONE: se parla italiano, sono disponibili per Lei servizi gratuiti di assistenza linguistica nonché aiuti e servizi ausiliari adeguati. Chiami il numero del Servizio per i membri riportato sul retro della Sua scheda identificativa del membro oppure il numero 800-565-9140 (TTY: 800-848-0298).

BAA'áKOHWIINIDZIN: Diné bizaad bee yáníłti'go, t'áá jiik'eh saad bee áka'anáda'awo' bee áka'anída'awo'í dóó t'áadoole'é binahji' bee adahodooníłígíí diné bich'į' anídahazt'i'í bee bika'aanída'awo'í ná dahóló. T'áá shóódí Bił Ha'dít'éhí Bika'anáda'awo' Bił Ha'dít'éhí ID naaltsoos nitł'izí bine'dęę' binámboo bee hodíilnih doodago 800-565-9140 (TTY: 800-848-0298).

WICHDICH: Wann du Deitsch schwetzscht un brauchscht Hilf fer communicat-e kenne mer dich helfe unni as es dich ennich eppes koschde zellt. Mir kenne differnti Sadde Schprooch-Hilf beigriege aa fer nix. Ruf der Member Service Number uff die hinnerscht Seit vun dei Member ID Card uff odder 800-565-9140 (TTY: 800-848-0298).

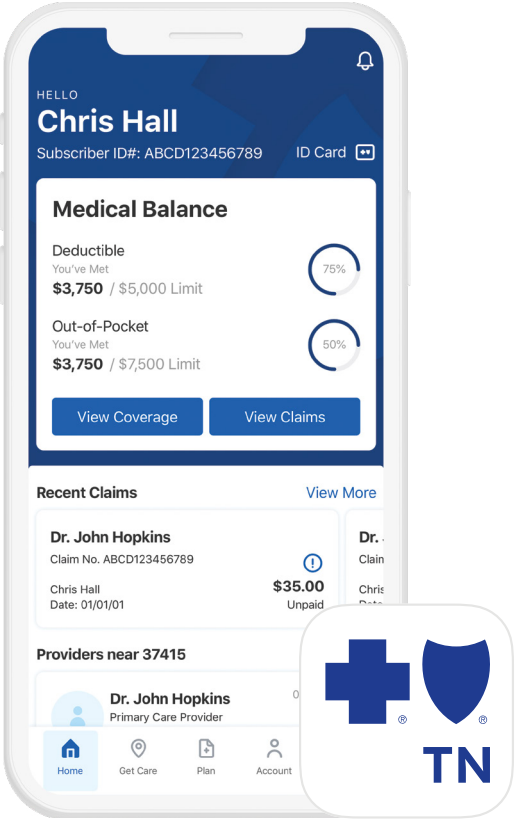
FAASILASILAGA: Afai e te tautala i le faa-Samoa, o loo avanoa mo oe auaunaga fesoasoani mo gagana e aunoa ma se totogi faapea ma fesoasoani fa'aopo'opo ma auaunaga talafeagai. Faamolemole vala'au le numera o le Member Service (Auaunaga mo Tagata Auai) o lo'o i tua o lau pepa ID o le Member (Tagata Auai) po o le 800-565-9140 (TTY: 800-848-0298).

GAKIULA: Gare iga go kapetal Faluwasch, ye toore paliuwal yamem bwe tepangug rel gamatefal lane kapetal Faluwasch. Fale peshem kol yegili nampal Member Service ila yelog liugul tagurul Member ID kard la yam gare 800-565-9140 (TTY: 800-848-0298).

ATENSION: Guaha setbisio siha para hågu yanggen fifino' CHamoru hao, dibåtde na setbision inayudon fumino' CHamoru yan propriu na inasisten tråstes yan setbisio siha. Put fabot ågang i numiron Setbision Membro gi santatten i kattå-mu Member ID pat 800-565-9140 (TTY: 800-848-0298).

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