Attachment C - Schedule of Benefits

PremierBlue Plan A48

Benefit percentages apply to the BCBST Maximum Allowable Charge. Network level applies to services received from Network Providers and Non-Contracted Providers.

Out-of-Network benefit percentages apply to BCBST Maximum Allowable Charge. Member is responsible for any amount exceeding the Maximum Allowable Charge for services received from Out-of-Network Providers and Non-Contracted Providers.

To receive the maximum benefit from this Policy, make sure the Provider is a member of the Provider Network shown on the membership ID card.

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Service Received at the Practitioner's office		
Office Services for Preventive Care		
Well Child Care - Children under age 6 Includes: • Exams • Immunizations • Preventive Screenings	100% after $35 Copayment	80% after Deductible
Well Woman Exam	100% after $35 Copayment	80% after Deductible
Preventive Mammogram, Cervical Cancer screening, and Prostate Cancer screening	100%	80% after Deductible
Preventive non-invasive colorectal screening (does not include flexible sigmoidoscopy or colonoscopy)	100%	80% after Deductible
Wellcare Services, age 6 and up Benefits for Wellcare are limited to $300 per Calendar Year. Includes: Annual health assessment Immunizations Preventive screenings, other than for cervical cancer, colorectal or prostate cancer	100% after $35 Copayment	80% after Deductible
Screening flexible sigmoidoscopy and screening colonoscopy Benefits for Wellcare are limited to $300 per Calendar Year	100% after $35 Copayment	80% after Deductible

Office Services for Diagnosis and Treatment of Illness or Injury Some procedures including Non-Routine Diagnostic Services require Prior Authorization. Call customer service to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, benefits will be reduced to 50% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). 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.		
Office visits for diagnosis and treatment of Illness or Injury. Primary Care Practitioner types (Family Practice, Internal Medicine, Pediatrics, Obstetrics & Gynecology, Physician Assistants, Nurse Practitioners) All other Practitioners	100% after $35 Copayment 100% after $50 Copayment	80% after Deductible 80% after Deductible
Office Surgery, including anesthesia Primary Care Practitioner types (Family Practice, Internal Medicine, Pediatrics, Obstetrics & Gynecology, Physician Assistants, Nurse Practitioners) All other Practitioners	100% after $35 Copayment 100% after $50 Copayment	80% after Deductible 80% after Deductible
Allergy Testing	100%	80% after Deductible
Allergy injections and allergy serum	100%	80% after Deductible
All other injections	100%	80% after Deductible
Non-Routine Diagnostic Services: CAT scans, MRI's, PET scans, nuclear medicine and other similar technologies.	100% after Deductible	80% after Deductible
All Other Diagnostic Services for illness or injury	100%	80% after Deductible
Therapy Services: Physical, speech, occupational, and manipulative limited to 20 visits per therapy type per Calendar Year; Cardiac and pulmonary rehab therapy limited to 36 visits per therapy type per Calendar Year	100% after Deductible	80% after Deductible
DME, Orthotics and Prosthetics	100% after Deductible	80% after Deductible
Supplies	100%	80% after Deductible
Behavioral Health Services Limited to $1,000 per calendar year	50% after Deductible	50% after Deductible
Provider Administered Specialty Pharmacy Products	100% after $50 Copayment	80% after Deductible

Services Received at a Facility		
Inpatient Hospital Stays Prior Authorization required. Benefits will be reduced to 50% for Out-of-Network Providers when Prior Authorization is not obtained. Benefits will be reduced to 50% for Network Providers outside Tennessee (BlueCard PPO Providers) 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	100% after Deductible	80% after Deductible
Practitioner Charges	100% after Deductible	80% after Deductible
Behavioral Health Services Limited to 20 days per calendar year	60% after Deductible	50% after Deductible
Skilled Nursing or Rehab Facility stays: (Limited to 30 days combined per Calendar Year) Prior Authorization required. Benefits will be reduced to 50% for Out-of-Network Providers when Prior Authorization is not obtained. Benefits will be reduced to 50% for Network Providers outside Tennessee (BlueCard PPO Providers) 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	100% after Deductible	80% after Deductible
Practitioner charges	100% after Deductible	80% after Deductible
Hospital Emergency Care services		
Facility Charges	$100 Copayment then 100% after Deductible – (Copayment is waived if patient is admitted to the hospital)	$100 Copayment then 100% after Deductible – (Copayment is waived if patient is admitted to the hospital)
Practitioner charges	100% after Deductible	100% after Deductible
Outpatient Facility Services **Outpatient Surgery** Some procedures including Non-Routine Diagnostic Services require Prior Authorization. Call customer service to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, benefits will be reduced to 50% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). 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. Surgeries include invasive diagnostic services (e.g. colonoscopy, sigmoidoscopy)		
Facility Charges	100% after Deductible	80% after Deductible
Practitioner charges	100% after Deductible	80% after Deductible

Outpatient Diagnostic Services Some procedures including Non-Routine Diagnostic Services require Prior Authorization. Call customer service to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, benefits will be reduced to 50% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). 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.		
Non-Routine Diagnostic Services for illness or injury: CAT scans, MRI's, PET scans, nuclear medicine and other similar technologies.	100% after Deductible	80% after Deductible
All other diagnostic services for illness or injury	100%	80% after Deductible
Diagnostic Services for Behavioral Health Services	50% after Deductible	50% after Deductible
Preventive screenings, under age 6	100%	80% after Deductible
Preventive Mammogram, Cervical Cancer screening, and Prostate Cancer screening	100%	80% after Deductible
Preventive non-invasive colorectal screening (does not include flexible sigmoidoscopy or colonoscopy)	100%	80% after Deductible
Other Wellcare Screenings, except flexible sigmoidoscopy or colonoscopy, age 6 and above Benefits for Wellcare are limited to $300 per Calendar Year.	100%	80% after Deductible
Screening colonoscopy or screening flexible sigmoidoscopy Benefits for Wellcare are limited to $300 per Calendar Year	100% after Deductible	80% after Deductible
Other Outpatient procedures, services, or supplies		
Therapy Services: Physical, speech, occupational, and manipulative limited to 20 visits per therapy type per Calendar Year; Cardiac and pulmonary rehab therapy limited to 36 visits per therapy type per Calendar Year	100% after Deductible	80% after Deductible
DME, Orthotics and Prosthetics	100% after Deductible	80% after Deductible
Supplies	100% after Deductible	80% after Deductible
Provider Administered Specialty Pharmacy Products	100% after Deductible	80% after Deductible
All Other services received at an outpatient facility, including chemotherapy, radiation therapy, injections, infusions, and renal dialysis	100% after Deductible	80% after Deductible

Prescription Drugs			
If Generic is available and You or Your physician elects Brand or Preferred Brand, You will be required to pay the difference between Brand or Preferred Brand and Generic Benefits are per 30 day supply	$10 Copayment for Generic Drugs		You pay all costs, then file for reimbursement. You will be reimbursed based on the Maximum Allowable Charge less any Copayment or Deductible amounts.
	$35 Copayment for Preferred Brand Name Drugs		
	$50 Copayment for Brand Name Drugs		
Self Administered Specialty Pharmacy products, as indicated on Our Specialty Pharmacy Products list Some Specialty medications require Prior Authorization. Call customer service to determine if Prior Authorization is required.			
Specialty Pharmacy Products	Benefits for Covered Services received from Specialty Pharmacy Network Providers	Benefits for Covered Services received from Network Pharmacies	Benefits for Covered Services received from Out-of-Network Pharmacies
	$50 Copayment	$100 Copayment	You pay all costs, then file for reimbursement. You will be reimbursed based on the Maximum Allowable Charge less any Copayment or Deductible amount
If a drug that is on Our Specialty Pharmacy Products list is also a Generic Drug or a Preferred Brand Drug, then Your Copayment will be:			
A Generic Drug that is also a Self Administered Specialty Pharmacy product, as indicated on Our Specialty Pharmacy Products list	$10 Copayment	$20 Copayment	You pay all costs, then file for reimbursement. You will be reimbursed based on the Maximum Allowable Charge less any Copayment or Deductible amount
A Preferred Brand Drug that is also a Self Administered Specialty Pharmacy product, as indicated on Our Specialty Pharmacy Products list	$35 Copayment	$70 Copayment	

Other Services		
Ambulance	100% after Deductible	100% after Deductible
Home Health Care Services, including home infusion therapy Prior Authorization is required. Limited to 40 visits per Calendar Year	100% after Deductible	80% after Deductible
Hospice Care	100%	80% after Deductible
DME, Orthotics and Prosthetics	100% after Deductible	80% after Deductible
Supplies	100% after Deductible	80% after Deductible

Organ Transplant Services			
Organ Transplant Services, all transplants except kidney All Organ Transplants require Prior Authorization. Benefits will be denied without Prior Authorization. Transplant Network Providers are different from Network Providers for other services. Call customer service before any pre-transplant evaluation or other transplant service is performed to request Authorization, and to obtain information about Transplant Network Providers. Network Providers that are not in the Transplant Network may balance bill the Member for amounts over TMAC not Covered by the Plan.	**Transplant Network** 100% after Network Deductible; Network Out -of-Pocket Maximum applies	**Network Providers not in Our Transplant Network (Network Providers not in our Transplant Network include Network Providers in Tennessee and BlueCard PPO Providers outside Tennessee)** 100% of Transplant Maximum Allowable Charge (TMAC) after Network Deductible, Network Out-of-Pocket Maximum applies. Amounts over TMAC do not apply to the Out-of-Pocket Maximum and are not Covered.	**Out-of-Network Providers** 80% of Transplant Maximum Allowable Charge (TMAC), after Out-of-Network Deductible, Out-of Network Out-of-Pocket Maximum applies. Amounts over TMAC do not apply to the Out-of-Pocket and are not Covered.
Organ Transplant Services, kidney transplants All Organ Transplants require Prior Authorization. Benefits will be denied without Prior Authorization. Transplant Network Providers are different from Network Providers for other services. Call customer service before any pre-transplant evaluation or other transplant service is performed to request Authorization, and to obtain information about Transplant Network Providers. Network Providers that are not in the Transplant Network may balance bill the Member for amounts over TMAC not Covered by the Plan.	**Network Providers:** 100% after Network Deductible; Network Out-of-Pocket Maximum applies		**Out-of-Network Providers**: 80% of Maximum Allowable Charge (MAC), after Out-of-Network Deductible, Out-of-Network Out-of- Pocket Maximum applies. Amounts over MAC do not apply to the Out-of- Pocket and are not Covered.

Miscellaneous Benefit Limits:	Network Providers	Out-of-Network Providers
Lifetime Maximum	$5 million	
TMJ - non-surgical treatment	$1,500 per Calendar Year	
Outpatient Behavioral Health Services	$1,000 per year	
Inpatient Behavioral Health Services	20 days per year	
All Behavioral Health Services	$20,000 per lifetime	
Dependent Age Limit	To age 24	
Pre-Existing Condition Waiting Period	12 Months	
4th Quarter Deductible Carryover	None	
	Services received from Network Providers	Services received from Out-of-Network Providers
Deductible		
Individual	$5,000	$10,000
Family	$15,000	$30,000
Out-of-Pocket Maximum (includes Deductible)		
Individual	$5,000	$13,000
Family	$15,000	$36,000