BENEFITS SUMMARY

PPO - $2,500 Deductible

of Tennessee

PersonalBlue lets you find the best plan for you and your budget. The $2,500 deductible option means your health plan benefits kick in after you pay $2,500 out of your own pocket. You can: **(1) choose your coinsurance, (2) choose your office visit copay, and (3) choose your prescription drug benefits** to create a plan just for you or for your whole family. You even have the option of adding maternity, dental or life coverage.

Choose your provider network – BlueNetwork P or BlueNetwork S – to gain access to doctors, hospitals and other health care providers at a discounted rate. Using a network provider allows you to take advantage of cost savings BlueCross BlueShield of Tennessee has negotiated on your behalf.

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Benefit Features		Network Provider		
Deductible		**Choose Your Coinsurance**	Out-of-Pocket Maximum (includes deductible)	
Individual	Family	Plan Pays	Individual	Family
$2,500	$7,500	**100%**	$2,500	$7,500
		80%	$5,500	$13,500

2

Benefits For Covered Services	Network Benefits		
Practitioner Office Services	**Choose Your Office Visit Copay**		
Office visit for diagnosis and treatment of illness or injury	**$35 PCP*/$50 Specialist Copay**	**$35 PCP*/$50 Specialist Copay** *(first 4 visits)* **Deductible/Coinsurance** *(fifth visit and beyond)*	**Deductible/Coinsurance**
Routine Diagnostic Lab, X-Ray	100%	100% *(first 4 visits)* Deductible/Coinsurance *(fifth visit and beyond)*	Deductible/Coinsurance
Advanced Radiological Imaging *(Includes CAT scans, CT Scans, MRI's, PET scans, nuclear medicine and other similar technologies)*	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Office Surgery *(Includes anesthesia performed in and billed by the practitioner's office)* *(Surgeries include incisions, excisions, biopsies, injection treatments, fracture treatments, applications of casts and splints, sutures, and invasive diagnostic services e.g., colonoscopy, sigmoidoscopy and endoscopy)*	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance

3

Benefits For Covered Services	Network Benefits		
Prescription Drug Options**	**Choose Your Prescription Drug Benefits**		
Generic Drugs	**$8 Copay**	**$8 Copay**	**50% with $2,000 Annual Maximum**
Preferred Brand Name Drugs	**$35 Copay**	**$35 Copay**	
Non-Preferred Brand Name Drugs	**$60 Copay**	**$60 Copay**	
Deductible on Brand Name Drugs *(separate from medical deductible)*	**$500 Brand Deductible** *(each member has to meet their own brand deductible before any benefits are paid for brand name drugs)*	**No Brand Deductible**	

Benefits For Covered Services	Network Benefits
Preventive Health Care Services	
Well Child Care *(to age 6)* Annual Well Care *(ages 6 and up)* Annual Well Woman Exam	100% after $35 copay *(no annual limit for covered services per calendar year for each person covered)*
Annual Mammography Screening Annual Cervical Cancer Screening Prostate Cancer Screening Immunizations	100% *(no annual limit for covered services per calendar year for each person covered)*
Services Received at a Facility	
Inpatient Services Skilled Nursing or Rehabilitation *(30 days per calendar year)* Outpatient Facility Services Outpatient Surgery Other Outpatient Services	Deductible/Coinsurance
Hospital Emergency Care	
Facility Charges	$100 Copay then Deductible/Coinsurance
Practitioner Charges	Deductible/Coinsurance
Therapy Services	
Physical, speech, occupational and manipulative *(limited to 20 visits per therapy per calendar year)* Cardiac and pulmonary rehab therapy *(limited to 36 visits per therapy per calendar year)*	Deductible/Coinsurance
Behavioral Health Services *(Limited to $20,000 per lifetime)*	
Inpatient Services *(Limited to 20 days per calendar year)*	100% after Deductible *(if you choose 100% coinsurance)* 60% after Deductible *(if you choose 80% coinsurance)*
Outpatient Services *(Limited to $1,000 per calendar year)*	100% after Deductible *(if you choose 100% coinsurance)* 50% after Deductible *(if you choose 80% coinsurance)*
Other Services	
Ambulance	Deductible/Coinsurance
Home Health Care Services *(40 per calendar year)*	Deductible/Coinsurance
Hospice Care	100%
Dependent Age Limit	To age 24
Pre-Existing Condition Waiting Period	12 months *(may be reduced if coming off a BCBST commercial group plan)*
Lifetime Maximum	$5 million per covered individual

**Primary Care Practitioners (PCP) = family practice, internal medicine, general practice, pediatrics, OB/GYN, physician assistant, nurse practitioner*
Specialist = all other

***The plan does not cover certain prescription drugs that have an over-the-counter alternative in the following prescription drug classes:*

- *Proton pump inhibitors are not covered except for patients: (1) who are 18 years or younger; (2) with Grade III erosive esophagitis confirmed by endoscopy; (3) with Grade IV erosive esophagitis confirmed by biopsy; or (4) with Zollinger-Ellison syndrome confirmed by diagnostic test.*
- *Histamine H2-Antgonists are not covered except for patients who are 18 years or younger.*
- *Second generation non-sedating antihistamines, which may also contain decongestants, are not covered, except for Zyrtec syrup prescribed for a member 2 years or younger.*

The plan does not cover any prescription drug for which there is an over-the-counter equivalent in both dosage and strength, except insulin.

***Note:** Certain Services require prior authorization. Out-of-network benefits are provided at 50 percent when prior authorization is not obtained. Out-of-network benefit percentages apply to BlueCross BlueShield of Tennessee's maximum allowable charge. The member is responsible for any amount exceeding the maximum allowable charge for services from out-of-network providers.*

Optional Coverage

Maternity Benefits – If you are thinking of starting a family, consider purchasing maternity benefits to cover prenatal care, delivery services and routine newborn nursery care at the hospital. The maternity rider is only offered at the time of initial enrollment or within 31 days of the qualifying events of marriage or loss of employer-sponsored coverage. Please note there is a 10-month waiting period from the effective date of the maternity rider before any maternity benefits will be paid.

Dental Benefits – Take care of your smile and your overall health with Personal Dental Coverage, another optional benefit that covers diagnostic, preventive, restorative services and much more. You can add the benefit anytime.

Term Life Benefits – This coverage from USAble Life* provides you with an affordable opportunity to bring your overall life insurance protection up to date while giving your family an extra measure of security. You may purchase Term Life insurance when you initially enroll in one of our medical plans.

Choose Blue…and Discover Advantages You Won't Find Anywhere Else

- **Freedom to Choose Any Provide**r – Receive the highest level of benefits when you choose network providers.
- **Convenient Automatic Claims Filing** – Your claims will be filed automatically when you use network providers.
- **Check Benefit Information and Claims Status Online** – Use BlueAccess at bcbst.com for benefit information such as the portion of your deductible you have met, prior authorization and claims status, view copies of your Explanation of Benefits and more.
- **An ID Card That's Recognized Around the World** – Travel with confidence knowing that your member ID card is widely recognized and accepted. BlueCard® Worldwide offers a special network of hospitals and doctors when you need medical care outside of the BlueCross BlueShield of Tennessee service area.
- **BluePerks®** – Receive up to a 50 percent discount on non-covered services from participating practitioners and facilities including: cosmetic services, weight loss programs, health club memberships, massage therapy, vision care, LASIK vision surgery and more. Visit bcbst.com to learn about other available discounts.

* USAble Life is an independent company that does not provide BlueCross BlueShield of Tennessee products or services.

Exclusions from Coverage

When a service or supply is excluded, all related expenses, services and supplies will also be excluded.

PersonalBlue policies do not provide benefits for the following services, supplies or charges:

1. Services or supplies not listed as covered services under Attachment A: covered services;
2. Services or supplies that are determined to be not medically necessary and appropriate or have not been authorized by BlueCross BlueShield of Tennessee;
3. Services or supplies that are investigational in nature including, but not limited to: (1) drugs, (2) biologicals; (3) medications; (4) devices; and (5) treatments;
4. When more than one treatment alternative exists, each is medically appropriate and medically necessary, and each would meet the member's needs, we reserve the right to provide payment for the least expensive covered service alternative;
5. Illness or injury resulting from war and covered by: (1) veteran's benefit; or (2) other coverage for which the member is legally entitled and that occurred before the member's coverage began under this policy;
6. Self-treatment or training;
7. Staff consultations required by hospital or other facility rules;
8. Services that are free;
9. Services required because of illness or injury related to the member's participation in a felony, attempted felony, riot or insurrection;
10. Services or supplies for the treatment of work related illness or injury, regardless of the presence or absence of workers' compensation coverage. This exclusion does not apply to injuries or illnesses resulting from self-employment;
11. Personal, physical fitness, recreational or convenience items and services such as: (1) barber and beauty services; (2) television; (3) air conditioners; (4) humidifiers; (5) air filters; (6) heaters; (7) physical fitness equipment; (8) saunas; (9) whirlpools; (10) water purifiers; (11) swimming pools; (12) tanning beds; (13) weight loss programs; (14) physical fitness programs; (15) self-help devices that are not primarily medical in nature, even if ordered by a practitioner; or (16) devices and computers to assist in communication or speech;
12. Services or supplies received before the member's effective date for coverage under a PersonalBlue policy;
13. Services or supplies related to a hospital confinement, received before the member's effective date for coverage under a PersonalBlue policy;
14. Services or supplies received after coverage under a PersonalBlue policy ceases for any reason. This is true even though the expenses relate to a condition that began while the member was covered;
15. Telephone, email or web-based consultations or telemedicine services, except as may be provided for by specially arranged care management or emerging health care programs as described in the prior authorization, care management, medical policy and patient safety section of this policy;
16. Charges for failure to keep a scheduled appointment;
17. Services for providing requested medical information including medical records or completing forms, including claim forms. We will not charge the member for statutorily authorized copying charges;
18. Court ordered examinations and treatment, unless medically necessary;
19. Room, board and general nursing care rendered on the date of discharge, unless admission and discharge occur on the same day;
20. Charges in excess of the maximum allowable charge for covered services or any charges that exceed the lifetime maximum.
21. Any service stated in Attachment A as a non-covered service or limitation;
22. Benefits for conditions that are listed in the benefit exclusion rider, if applicable, are excluded, as stated in the rider;
23. Charges for Services performed by you or your spouse, or your or your spouse's parent, sister, brother or child;
24. Services and supplies for pre-existing conditions during the pre-existing condition waiting period;
25. Services for which the member is not legally obligated to pay or for which no charge would be made if the member had no health insurance coverage;
26. Any charges for handling fees;
27. Services or supplies, including bariatric surgery, for weight loss or to treat obesity, even if you have other health conditions that might be helped by weight loss or reduction of obesity. This exclusion applies whether you are of normal weight, overweight, obese or morbidly obese;
28. Safety items, or items to affect performance primarily in sports-related activities;
29. Cosmetic services. This exclusion also applies to surgeries to improve appearance following a prior surgical procedure, even if that prior procedure was a covered service. Cosmetic services include, but are not limited to: (1) removal of tattoos; (2) facelifts; (3) keloid removal; (4) dermabrasion; (5) chemical peels; (6) breast augmentation; (7) lipectomy; (8) body contouring or body modeling; (9) injections to smooth wrinkles, including but not limited to Botox; (10) laser resurfacing, (11) sclerotherapy injections, laser or other treatment for spider veins and varicose veins, except as appropriate per Medical Policy, (12) piercing ears or other body parts, (13) rhytidectomy or rhytidoplasty (Surgery for the removal or elimination of wrinkles), (14) rhinoplasty, except as appropriate per medical policy, (15) panniculectomy, (16) abdominoplasty, (17) thighplasty, (18) brachioplasty;
30. Services or supplies related to treatment of complications (except complications of pregnancy) that are a direct or closely related result of a member's refusal to accept treatment, medicines, or a course of treatment that a provider has recommended or that has been determined to be medically necessary. This includes leaving an inpatient medical facility against the advice of the treating physician;
31. Blepharoplasty and browplasty, except for: (1) correction of injury to the orbital area resulting from physical trauma or non-cosmetic surgical procedures (e.g., removal of malignancies); (2) treatment of edema and irritation resulting from Grave's disease; or (3) correction of trichiasis, ectropion, or entropion of the eyelids;
32. Sperm preservation;
33. Services and supplies for orthognathic surgery;
34. Services and supplies for maintenance care;
35. Private duty nursing;
36. Pharmacogenetic testing or pharmacogenomics (a procedure or test to determine how a drug will be metabolized by an individual, given that individual's genetic makeup);
37. Services or supplies for methadone, methadone maintenance therapy, buprenorphine and buprenorphine maintenance therapy;
38. Cranial orthosis, including helmet or headband, for the treatment of plagiocephaly;
39. Services or supplies to treat sexual dysfunction, regardless of cause, including but not limited to erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido;
40. Services or supplies related to complications of cosmetic procedures, complications of bariatric surgery; re-operation of bariatric surgery or body remodeling after weight loss;
41. Chelation therapy, except for (1) control of ventricular arrhythmias or heart block associated with digitalis toxicity; (2) emergency treatment of hypercalcemia; (3) extreme conditions of metal toxicity, including thalassemia with hemosiderosis; (4) Wilson's disease (hepatolenticular degeneration); and (5) lead poisoning;
42. Vagus nerve stimulation for the treatment of depression;
43. Artificial intervertebral disc;
44. Balloon sinuplasty for treatment of chronic sinusitis;
45. Treatment for benign gynecomastia;
46. Treatment for hyperhidrosis; and
47. Percutaneous intradiscal electrothermal annuloplasty and percutaneous intradiscal radiofrequency thermocoagulation to treat chronic discogenic back pain. These procedures allow controlled delivery of heat to the intervertebral disc through an electrode or coil.

This is a summary and not all inclusive. Your policy provides a complete list of benefits, limitations, exclusions and provisions. Certain medical conditions may be excluded.

of Tennessee

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USAble Life is solely responsible for the Life coverage above.

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