BlueCross BlueShield of Tennessee
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COMM-PPO-115 (3/03)

Guaranteed Issue Policy Features

Plan Number		In-Network						Out-of-Network					
Without Maternity	With Maternity	Deductible		Benefit Payments		Out-of-Pocket Maximum[1,2] (includes deductible)		Deductible		Benefit Payments[3]		Out-of-Pocket Maximum[1,2] (includes deductible)	
		Individual	Family	Plan Pays	You Pay	Individual	Family	Individual	Family	Plan Pays	You Pay	Individual	Family
H31		$500	$1,500	80%	20%	$1,500	$3,500	$1,000	$3,000	60%	40%	$4,000	$9,000
H32	H32M	$1,000	$3,000	80%	20%	$2,000	$5,000	$2,000	$6,000	60%	40%	$5,000	$12,000

Features Common To Each Plan Option

Dependent Age Limit .... Age 24

Lifetime Benefit Maximum Amount $5,000,000

Prescription Drug Benefits .... $10 copay for generic
$35 copay for BlueCross BlueShield of Tennessee preferred brand
$50 non-preferred brand

Pre-existing Condition Waiting Period .... 12 Months

Waived for BlueCross BlueShield of Tennessee group conversions or those individuals exercising their federal continuation of coverage rights under the Health Insurance Portability and Accountability Act. Inter-plan transfers will be credited for the time covered by their previous BlueCross BlueShield policy.

Effective Date .... Coverage automatically begins the day after your previous creditable coverage ends if your application is received in a timely manner.

Covered Services

- Medically necessary and appropriate services in a practitioner's office.
- Routine diagnostic services.
- Injections.
- Inpatient hospitalization including room and board in a semi-private room, general nursing care, medications, injections, diagnostics and special care units.*
- Outpatient facility services, including, outpatient surgery centers, hospital outpatient centers and outpatient diagnostic centers.*
- Emergency care services.
- Skilled nursing and rehabilitation facilities (30-day annual limit).
- Non-routine diagnostic services.
- Therapeutic services including physical therapy, speech therapy, occupational therapy and manipulative therapy (20-visit limit per year, per therapy). Therapeutic services for cardiac and pulmonary rehabilitative services (36-visit limit per year, per therapy).
- Durable medical equipment, prosthetics and orthotics.
- Home health services (40-visit limit per year).
- Ambulance services.
- Hospice.
- Organ transplants.
- TMJ (non-surgical/$1,500 annual limit).
- Behavioral health programs including coverage for inpatient and outpatient services for care and treatment of mental health disorders and substance abuse disorders (20-day annual inpatient services limit; $1,000 annual outpatient services limit; two episodes per lifetime limit on substance abuse treatment).
- Sterilization.

* Certain services require prior approval. Out-of-network benefits are provided at 50 percent when prior approval is not obtained.

Optional Maternity Benefits (available with H32 only for an additional premium)

- Prenatal care
- Delivery services
- Routine newborn nursery care at the hospital

Maternity benefits will be paid on the same basis as any other illness, and subject to all policy provisions.

Note: The maternity rider is only available at the time of initial purchase. The rider may only be added at a later date under the qualifying event of marriage.

1. Out-of-pocket maximums for in-network and out-of-network covered services are separate and do not combine.
2. The plan pays 100 percent of covered services for the remainder of the plan year after the deductible and the out-of-pocket maximum have been met, up to the lifetime benefit maximum amount.
3. Out-of-network benefit payment based on BlueCross BlueShield of Tennessee maximum allowable charge. Member is responsible for paying any amount exceeding the maximum allowable charge.

NOTE: Behavioral health benefits are subject to a 60 percent coinsurance percentage for inpatient services, and a 50 percent coinsurance percentage for outpatient services. The behavioral health coinsurance amounts do not apply to the out-of-pocket maximum.

What Is Not Covered

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

1. Benefits for pre-existing conditions are excluded until any pre-existing waiting periods have been met;
2. Services or supplies that are determined to not be medically necessary and appropriate or have not been authorized by BlueCross BlueShield of Tennessee;
3. Illness or injury resulting from war and covered by veteran's benefits. Other coverage for which the member is legally entitled and which occurred before the member's coverage began under this policy;
4. Non-medical self treatment or training;
5. Staff consultations required by hospital or other facility rules;
6. Services which are free;
7. Services required as a result of an attempt, commission or fleeing of a felony by the member;
8. Any work-related illness or injury unless resulting from self-employment;
9. Personal and 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; and (12) tanning beds. Other recreational equipment including: (1) weight loss programs; (2) physical fitness programs; or (3) self-help devices which are not primarily medical in nature, even if ordered by a practitioner. Motorized scooters, deluxe or enhanced equipment. In all instances, the most basic equipment needed to provide the needed medical care will determine the benefit;
10. Services or confinements that occurred before the member's effective date for coverage under this policy;
11. Services or supplies received in a dental or medical department maintained by or on behalf of a member's employer, mutual benefit association, labor union or similar group;
12. Telephone consultations, or charges for failure to keep a scheduled appointment;
13. Services for providing requested medical information or completing forms;
14. Court-ordered examinations and treatment, unless medically necessary;
15. Room, board and general nursing care rendered on the date of discharge, unless admission and discharge occur on the same day;
16. Charges in excess of the maximum allowable charge for covered services or any charges which exceed the lifetime maximum;
17. Charges for services performed by you or your spouse, or you or your spouse's parent, sister, brother or child, are not covered;
18. Normal pregnancy, delivery or routine newborn nursery care unless covered by maternity rider;
19. Routine foot care;
20. Custodial, domicilliary or private duty nursing services;
21. Services or supplies that are designed to medically enhance a member's level of fertility in the absence of a disease;
22. Assisted reproductive technology (ART), such as *GIFT, ZIFT,* invitrofertilization and fertility drugs;
23. Elective abortions;
24. Services, supplies or prosthetics primarily to improve appearance;
25. Surgeries and related services to change gender;
26. Services and supplies to detect or correct refractive errors of the eyes;
27. Eyeglasses, contact lenses and examination for the fitting of eyeglasses and contact lenses;
28. Any service stated in Attachment A of the Guaranteed Issue Policy as a non-covered service or limitation;
29. Services or supplies not listed as covered services under Attachment A, Covered Services of the Guaranteed Issue Policy;
30. Services or supplies for the reversal of sterilization;
31. Hearing aids;
32. Prosthetics primarily for cosmetic purposes, including but not limited to wigs, or other hair prosthesis or transplants;
33. Items to replace those that were lost, damaged, stolen, or prescribed as a result of new technology;
34. Supplies/drugs that can be purchased without a prescription;
35. Any drug that is purchased outside the United States except those authorized by BlueCross BlueShield of Tennessee;
36. Any quantity of prescription drugs which exceed that specified by BlueCross BlueShield of Tennessee Pharmacy and Therapeutics Committees;
37. Handling fees;
38. Services or supplies related to obesity, including surgical or other treatment of morbid obesity; and
39. Human growth hormones, except for: (1) treatment of absolute growth hormone deficiency in children whose epiphyses have not closed; and (2) treatment of patients with "Turner" syndrome, including the drugs, (1) Genotropin; (2) Humatrope; (3) Norditropin; (4) Nutropin; (5) Saizen; (6) Serostim; (7) Somatropin; and (8) Protropin (Somatrem).

This brochure is a summary and is not all inclusive. Your policy provides a complete list of benefits, limitations, exclusions and provisions.

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