Health Benefit Plan Evidence of Coverage

City of Gallatin
109340 - Option 1 – Network S
October 1, 2012

of Tennessee

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

COMM-662 (2/12)
Member

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

City of Gallatin
109340 - Option 1 – Network S
October 1, 2012

BCBST-Core4
9/2008, revised 10/2011

BlueCross BlueShield of Tennessee

Evidence of Coverage

Please read this Evidence of Coverage carefully and keep it in a safe place for future reference. It explains Your Coverage from BlueCross BlueShield of Tennessee.

If You have questions about this Evidence of Coverage or any matter related to Your membership in the Plan, please write or call us at:

Customer Service Department
BlueCross BlueShield of Tennessee
1 Cameron Hill Circle
Chattanooga, Tennessee 37402-2555
(800) 565-9140

BCBST-Core4
9/2008, revised 10/2011

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Get the Most from Your Benefits

1. **Please Read Your Evidence of Coverage**. - This Evidence of Coverage (this "EOC") is part of the Group Agreement between BlueCross BlueShield of Tennessee, Inc. (BCBST, or the "Plan") and Your Group. This EOC describes the terms and conditions of Your Coverage from the Plan through the Group, and includes all riders and attachments, which are incorporated herein by reference. It replaces and supersedes any EOC that You have previously received from the Plan.

   Please read this EOC carefully. It describes Your rights and duties as a Member. It is important to read the entire EOC. Certain services are not Covered by the Plan. Other Covered Services are limited. The Plan will not pay for any service not specifically listed as a Covered Service, even if a health care Provider recommends or orders that non-Covered Service. (See Attachments A – D.)

   The Group has delegated discretionary authority to the Plan to make any benefit or eligibility determinations. It has also granted the authority to construe the terms of Your Coverage to the Plan. The Plan shall be deemed to have properly exercised that authority unless it abuses its discretion when making such determinations, whether or not the Group's benefit plan is subject to ERISA. "ERISA" means the Employee Retirement Income Security Act.

   Any Grievance related to Your Coverage under this EOC must be resolved in accordance with the Grievance Procedure section of this EOC.

   Definitions: In order to make it easier to read and understand this EOC, defined words are capitalized. Those words are defined in the "DEFINITIONS" section of this EOC.

   Questions: Please contact one of the Plan's consumer advisors at the number listed on Your membership ID card, if You have any questions when reading this EOC. Our consumer advisors are also available to discuss any other matters related to Your Coverage from the Plan.

2. **How a PPO Plan Works -** You have a PPO plan. BlueCross BlueShield of Tennessee contracts with a network of doctors, hospitals and other health care facilities and professionals. These Providers, called Network Providers, agree to special pricing arrangements.

   Your PPO plan has two levels of benefits. By using Network Providers, You receive the highest level of benefits. However, You can choose to use Providers that are not Network Providers. These Providers are called Out-of-Network Providers. When You use Out-of-Network Providers, Your benefits will be lower. You will also be responsible for amounts that an Out-of-Network Provider bills above Our Maximum Allowable Charge and any amounts not Covered by Your Plan.

   The Attachment C: Schedule of Benefits, shows how Your benefits vary for services received from Network and Out-of-Network Providers. Attachment C also will show You that the same service might be paid differently depending on where You receive the service. Attachment A details Covered Services and exclusions, and Attachment B lists services excluded under the Plan.

   By using Network Providers, You maximize Your benefits and avoid balance billing. Balance billing happens when You use an Out-of-Network Provider and You are billed the difference between the Provider's price and the Maximum Allowable Charge. This amount can be substantial.

3. **Your BlueCross BlueShield of Tennessee Identification Card** - Once Your Coverage becomes effective, You will receive a BlueCross BlueShield of Tennessee, Inc. membership identification (ID) card. Doctors and hospitals nationwide recognize it. The membership ID card is the key to receiving the benefits of the health plan. Carry it at all times. Please be sure to show the membership ID card each time You receive medical services, especially whenever a Provider recommends hospitalization.

   Our customer service number is on Your membership ID card. This is an important phone number. Call this number if You have any questions. Also, call this number if You are receiving Hospital Services from Providers outside of Tennessee or from Out-of-Network Providers to make sure all

Prior Authorization procedures have been followed. See the section entitled "Prior Authorization" for more information.

If a membership ID card is lost or stolen, or another card is needed for a Covered Dependent not living with the Subscriber, use Member self-service on bcbst.com, or call the toll-free number listed on the front page of this EOC. We will help You get a new one. You may want to record Your identification number in this book.

Important: Please present Your BlueCross BlueShield of Tennessee ID card at each visit to a physician's office, hospital, pharmacy or other health care Provider**.**

4. Always **carry Your membership ID card** and show it before receiving care.
5. **Always use Network Providers**, including pharmacies, durable medical equipment suppliers, skilled nursing facilities and home infusion therapy Providers. See Attachment A for an explanation of a Network Provider. Call the customer service department to verify that a Provider is a Network Provider, or visit www.bcbst.com and click on Find a Doctor.

   If Your doctor refers You to another doctor, hospital or other health care Provider, or You see a covering physician in Your doctor's practice, please make sure that the Provider is a Network Provider. When using Out-of-Network providers, You will be responsible for the difference in the Provider's billed charge and the Maximum Allowable Charge. This amount can be substantial.
6. Ask customer service if the Provider is in the specific network shown on Your membership ID card. Since BCBST has several PPO networks, a Provider may be in one BCBST network, but not in all of Our networks. Check out Our website, www.bcbst.com, for more information on Providers in each PPO network.
7. To find out if BCBST considers a recommended service to be Medically Necessary, please refer to Our Medical Policy Manual at www.bcbst.com. Search for Medical Policy Manual. Note that decisions about whether a service is experimental/investigational or medically necessary are for the purposes of determining what is covered under the EOC. You and Your doctor decide what services You will receive.
8. **Use the BlueCard PPO network when You need Covered Services outside of Tennessee.** Call the toll-free number shown on Your membership ID card to find a network Provider outside of Tennessee, or visit www.bcbst.com and click on Find a Doctor. Use the BlueCard PPO network when You need Covered Services outside of Tennessee.
9. **Prior Authorization is required for certain services.** See page 13 for a partial list. Make sure Your Provider obtains Prior Authorization before any planned hospital stays (except maternity admissions), skilled nursing and rehabilitative facility admissions, certain outpatient procedures, Advanced Radiological Imaging services, certain Specialty Drugs, and Durable Medical Equipment costing $500 or more. Call Our customer service department to find out which services require Prior Authorization. You can also call the customer service department to find out if Your admission or other service has received Prior Authorization.
10. To save money when getting a prescription filled, **ask if a generic equivalent is available**.
11. In a true Emergency it is appropriate to go to an Emergency room (see Emergency definition in the Definitions Section of this EOC.) However, **most conditions are not Emergencies and are best handled with a call to Your doctor's office.** You can also call Your doctor on nights and weekends where Our network physicians provide a covering health care professional to return Your call.

    You also can call the 24/7 Nurseline, where a Registered Nurse will help decide what kind of care is needed. Call toll-free 1-800-818-8581 to speak one-on-one with a Registered Nurse.
12. Ask that Your Provider **report any Emergency admissions to BCBST** within 24 hours or the next business day.

13. Get a **second opinion** before undergoing elective Surgery.
14. Get support if You are facing a medical decision by calling 1-800-818-8581. Many conditions have more than one valid treatment option. Our health coaches can help You discuss these treatment options with Your doctor so that You can make an informed decision. Some common conditions with multiple treatment options include:
    - Back pain;
    - Heart bypass surgery and angioplasty;
    - Women's health including uterine problems, hysterectomy, maternity, menopause, hormone replacement, and ovarian cancer; arthritis of the major joints;
    - Men's health, including benign prostatic hyperplasia, cancer, and PSA testing;
    - Breast cancer and ductal carcinoma in situ, including surgical and other therapy, and reconstruction;
    - End-of-life care.
15. Notify Your Employer if changes in the following occur for You or any of Your dependents:
    - Name.
    - Address.
    - Telephone number.
    - Employment (change companies or terminate employment).
    - Status of any other health insurance You might have.
    - Birth of additional dependents.
    - Marriage or divorce.
    - Death.
    - Adoption.

Enrolling in the Plan

Eligible Employees may enroll for Coverage for themselves and their eligible dependents as set forth in this section. No person is eligible to re-enroll if the Plan previously terminated his or her Coverage for cause. Your Group chooses the classes of Employees who are eligible for Coverage under the Plan. Please refer to Attachment D: Eligibility for details.

A. Initial Enrollment Period

Eligible Employees may enroll for Coverage for themselves and their eligible dependents within the first 31 days after becoming eligible for Coverage. The Subscriber must: (1) include all requested information; (2) sign; and (3) submit an Enrollment Form to the Plan during that initial enrollment period.

B. Open Enrollment Period

Eligible Employees shall be entitled to apply for Coverage for themselves and eligible dependents during the Group's Open Enrollment Period. The Subscriber must: (1) include all requested information; (2) sign; and (3) submit an Enrollment Form to the Plan during that Open Enrollment Period. Employees who become eligible for Coverage other than during an Open Enrollment Period may apply for Coverage for themselves and eligible dependents within 31 days of becoming eligible for Coverage, or during a subsequent Open Enrollment Period.

C. Adding Dependents

After the Subscriber is Covered, he or she may apply to add a dependent, who became eligible after the Subscriber enrolled as follows:

1. A newborn child of the Subscriber or the Subscriber's spouse is Covered from the moment of birth. A legally adopted child (including children placed with You for the purposes of adoption) will be Covered as of the date of adoption or placement for adoption. Children for whom the Subscriber or the Subscriber's spouse has been appointed legal guardian by a court of competent jurisdiction will be Covered from the moment the child is placed in the Subscriber's physical custody. The Subscriber must enroll the child within 31 days from the date that the Subscriber acquires the child.

   If the Subscriber fails to do so, and an additional Premium is required to cover the child, the Plan will not cover the child after 31 days from the date the Subscriber acquired the child. If no additional Premium is required to provide Coverage to the child, the Subscriber's failure to enroll the child does not make the child ineligible for Coverage.

   However, the Plan cannot add the newly acquired child to the Subscriber's Coverage until notified of the child's birth. This may delay claims processing.

2. Any other new family dependent, (e.g. if the Subscriber marries) may be added as a Covered Dependent if the Subscriber completes and submits a signed Enrollment Form to the Group representative within 31 days of the date that person first becomes eligible for Coverage.

3. An Employee or eligible dependent who did not apply for Coverage within 31 days of first becoming eligible for Coverage under this Plan may enroll if:

   a. he or she had other health care coverage at the time Coverage under this Plan was previously offered; and

   b. he or she stated, in writing, at the time Coverage under this Plan was previously offered, that such other coverage was the reason for declining Coverage under this Plan; and

c. such other coverage is exhausted (if the other coverage was continuation coverage under COBRA) or the other coverage was terminated because he or she ceased to be eligible due to involuntary termination or employer contributions for such coverage ended; and

d. he or she applies for Coverage under this Plan and the administrator receives the change form within 31 days after the loss of the other coverage.

D. Late Enrollment

Employees or their family dependents who do not enroll when becoming eligible for Coverage under (A), (B) or (C), above, may be enrolled:

1. During a subsequent Open Enrollment Period; or

2. If the Employee acquires a new dependent, and the Employee applies for Coverage within 31 days.

If Your Group has 25 or fewer eligible Employees, please refer to the section headed Late Enrollment for Employees of Small Groups in Attachment D: Eligibility for more information.

E. Enrollment Upon Change in Status

If You have a change in status, You may be eligible to change Your Coverage other than during the Open Enrollment Period. Subscribers must, within the time-frame set forth below, submit a change form to the Group representative to notify the Plan of any changes in status for themselves or for a Covered Dependent. Any change in Your elections must be consistent with the change in status.

1. You must request the change within 31 days of the change in status for the following events: (1) marriage or divorce; (2) death of the Employee's spouse or dependent; (3) change in dependency status; (4) Medicare eligibility; (5) coverage by another Payor; (6) birth or adoption of a child of the Employee; (7) termination of employment, or commencement of employment, of the Employee's spouse; (8) switching from part-time to full-time, or from full-time to part-time status by the Employee or the Employee's spouse;

2. You must request the change within 60 days of the change in status for the following events: (1) loss of eligibility for Medicaid or CHIP coverage, or (2) becoming eligible to receive a subsidy for Medicaid or CHIP coverage.

When Coverage Begins

If You are eligible, have enrolled and have paid or had the Premium for Coverage paid on Your behalf, Coverage under this EOC shall become effective on the earliest of the following dates, subject to the Actively at Work Rule set out below:

A. Effective Date of Group Agreement

Initial Coverage through the Plan shall be effective on the effective date of the Group Agreement, if all eligibility requirements are met as of that date; or

B. Enrollment During an Open Enrollment Period

Coverage shall be effective on the first day of the month following the Open Enrollment Period, unless otherwise agreed to by the Group and the Plan; or

C. Enrollment During an Initial Enrollment Period

Coverage shall be effective on the first day of the month following the Plan's receipt of the eligible Employee's Enrollment Form, unless otherwise agreed to by the Group and the Plan; or

D. Newly Eligible Employees

Coverage will become effective after You become eligible, having met all the eligibility requirements as specified in the Group Agreement; or

E. Newly Eligible Dependents

(1) Dependents acquired as the result of a marriage – Coverage will be effective on the day of the marriage unless otherwise agreed to by Group and the Plan;

(2) Newborn children of the Subscriber or the Subscriber's spouse - Coverage will be effective as of the date of birth;

(3) Dependents adopted or placed for adoption – Coverage will be effective as of the date of adoption or placement for adoption, whichever is first.

For Coverage to be effective, the dependent must be enrolled, and the Plan must receive any required Premium for the Coverage, as set out in the "Enrollment" section; or

F. Eligibility For Extension of Benefits From a Prior Carrier

If the Plan replaces another group health plan and a Member is Totally Disabled and eligible for an extension of coverage from the prior group health plan, Coverage shall not become effective until the expiration of that extension of coverage; or

G. Actively at Work Rule

If an eligible Employee, other than a retiree (who is otherwise eligible), is not Actively at Work on the date Coverage would otherwise become effective, Coverage for the Employee and all of his/her Covered Dependents will be deferred until the date the Employee is Actively at Work. An employee who is not at work on the date Coverage would otherwise become effective due to a health-related factor shall be treated as Actively At Work for purposes of determining eligibility.

When Coverage Ends

A. Termination or Modification of Coverage by the Plan or the Group

The Plan or the Group may modify or terminate the Group Agreement. Notice to the Group of the termination or modification of the Group Agreement is deemed to be notice to all Members of the Group. The Group is responsible for notifying You of such a termination or modification of Your Coverage.

All Members' Coverage through the Agreement will change or terminate at 12:00 midnight on the date of such modification or termination. The Group's failure to notify You of the modification or termination of Your Coverage shall not be deemed to continue or extend Your Coverage beyond the date that the Group Agreement is modified or terminated. You have no vested right to Coverage under this EOC following the date of the termination of the Group Agreement.

B. Loss of Eligibility

Your Coverage will terminate if You do not continue to meet the eligibility requirements agreed to by the Group and the Plan during the term of the Group Agreement. See Attachment D for details regarding Loss of Eligibility.

C. Termination of Coverage For Cause

The Plan may terminate Your Coverage for cause, if:

1. The Plan does not receive the required Premium for Your Coverage when it is due. The fact that You have paid a Premium contribution to the Group will not prevent the Plan from terminating Your Coverage if the Group fails to submit the full Premium for Your coverage to the Plan when due, or
2. You fail to make a required Member Payment; or
3. You fail to cooperate with the Plan as required by this EOC; or
4. You have made a material misrepresentation or committed fraud against the Plan. This provision includes, but is not limited to, furnishing incorrect or misleading information or permitting the improper use of the membership ID card.

D. Right To Request A Hearing

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

E. Payment For Services Rendered After Termination of Coverage

If You receive Covered Services after the termination of Your Coverage, the Plan may recover the amount paid for such Services from You, plus any costs of recovering such Charges, including attorney's fees.

F. Extended Benefits

If a Member is hospitalized on the date the Group Agreement is terminated, benefits for Hospital Services will be provided: (1) for 60 days; (2) until the Member is Covered under another Plan; or (3) until the Member is discharged, whichever occurs first. The provisions of this paragraph will not apply to a newborn child of a Subscriber if an application for Coverage for that child has not been made within 31 days following the child's birth.

Continuation of Coverage

A. Continuation of Coverage - Federal Law

If the Group Agreement remains in effect, but Your Coverage under this EOC would otherwise terminate, the Group may be required to offer You the right to continue Coverage. This right is referred to as "Continuation Coverage" and may occur for a limited time subject to the terms of this Section and the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

1. Eligibility

   If You have been Covered by the Plan on the day before a qualifying event, You and Your dependents may be eligible for COBRA Continuation Coverage. The following are qualifying events for such Coverage if, under the terms of this EOC, the event causes You or Your spouse or dependent to lose coverage:

   a. Subscribers

      Loss of Coverage because of:

      (1) The termination of employment except for gross misconduct.

      (2) A reduction in the number of hours worked by the Subscriber.

   b. Covered Dependents

      Loss of Coverage because of:

      (1) The termination of the Subscriber's Coverage as explained in subsection (a), above.

      (2) The death of the Subscriber.

      (3) Divorce or legal separation from the Subscriber.

      (4) The Subscriber becomes entitled to Medicare. (Note: Medicare entitlement rarely qualifies a dependent for COBRA.)

      (5) A Covered Dependent reaches the limiting age.

2. Enrolling for COBRA Continuation Coverage

   The Group shall notify You of Your rights to enroll for COBRA Continuation Coverage after:

   a. the Subscriber's termination of employment, reduction in hours worked, death or entitlement to Medicare Coverage; or

   b. the Subscriber or Covered Dependent notifies the Group, in writing, within 60 days after any other qualifying event set out above.

   You have 60 days from the later of the date of the qualifying event or the date that You receive notice of Your right to COBRA Continuation Coverage to enroll for such Coverage. The Group will send You the forms that should be used to enroll for COBRA Continuation Coverage. If You do not send the Enrollment Form to the Group within that 60--day period, You will lose Your right to COBRA Continuation Coverage under this Section. If You are qualified for COBRA Continuation Coverage and receive services that would be Covered Services, before enrolling and paying the Premium for such Coverage, You will be required to pay for those services. The Plan will reimburse You for Covered Services, less required Member Payments, after You enroll and pay the Premium for Coverage, and submit a claim for those Covered Services as set forth in this EOC.

3. Premium Payment

You must pay any Premium required for COBRA Continuation Coverage to the Group, which will send that Premium to the Plan. The Group may also direct You to send Your Premium directly to the Plan, or a third party. If You do not enroll when first becoming eligible, the premium due for the period between the date You first become eligible and the date You enroll for COBRA Continuation Coverage must be paid to the Group within 45 days after the date You enroll for COBRA Continuation Coverage. After enrolling for COBRA Continuation Coverage, all Premiums are due and payable on a monthly basis as required by the Group. If the Premium is not received by the Plan on or before the due date, whether or not the Premium was paid to the Group, Coverage will be terminated, for cause, effective as of the last day for which Premium was received as explained in the Termination of Coverage Section.

4. Coverage Provided

If You enroll for COBRA Continuation Coverage You will continue to be Covered under the Group Agreement and this EOC. The COBRA Continuation Coverage is subject to the conditions, limitations and exclusions of this EOC and the Group Agreement. The Plan and the Group may agree to change the Group Agreement, and/or this EOC, and the Group may also decide to change insurers. If this happens after You enroll for COBRA Continuation Coverage, Your Coverage will be subject to such changes.

5. Duration of Eligibility for COBRA Continuation Coverage

COBRA Continuation Coverage is available for a maximum of:

a. 18 months if the loss of Coverage is caused by termination of employment or reduction in hours of employment; or

b. 29 months of Coverage. If, as a qualified beneficiary who has elected 18 months of COBRA Continuation Coverage, You are determined to be disabled within the first 60 days of COBRA Continuation Coverage, You can extend Your COBRA Continuation Coverage for an additional 11 months, up to 29 months. Also, the 29 months of COBRA Continuation Coverage is available to all non-disabled qualified beneficiaries in connection with the same qualifying event. “Disabled” means disabled as determined under Title II or XVI of the Social Security Act. In addition, the disabled qualified beneficiary must:

   (1) Notify the Employer or the administrator of the disability determination within 60 days after the determination of disability and before the close of the initial 18-month Coverage period; and

   (2) Notify the Employer or the administrator within 30 days of the date of a final determination that the qualified beneficiary is no longer disabled; or

c. 36 months of Coverage if the loss of Coverage is caused by:

   (1) the death of the Subscriber;

   (2) loss of dependent child status under the Plan;

   (3) the Subscriber becomes entitled to Medicare; or

   (4) divorce or legal separation from the Subscriber; or

d. 36 months for other qualifying events. If, a Covered Dependent is eligible for 18 months of COBRA Continuation Coverage as described above, and there is a second qualifying event (e.g. divorce), You may be eligible for 36 months of COBRA Continuation Coverage from the date of the first qualifying event.

6. Termination of COBRA Continuation Coverage

   After You have elected COBRA Coverage, Your COBRA Coverage will terminate either at the end of the applicable 18-, 29- or 36-month eligibility period or, before the end of that period, upon the date that:

   a. The Premium for such Coverage is not paid when due; or

   b. You become Covered as either a Subscriber or dependent by another group health care plan, that does not exclude or limit coverage of Your Pre-existing Condition, if any; or

   c. The Group Agreement is terminated; or

   d. You become entitled to Medicare Coverage; or

   e. The date that a disabled Member, who is otherwise eligible for 29 months of COBRA Coverage, is determined to no longer be disabled for purposes of the COBRA law.

7. The Trade Adjustment Assistance Reform Act of 2002 (TAARA) may have added to Your COBRA rights. If You lost Your job because of import competition or shifts of production to other countries, You may have a second COBRA Continuation election period. If You think this may apply to You, check with Your Employer or the Department of Labor.

B. State Continuation Coverage

If the Group Agreement remains in effect, but Your Coverage under this EOC would otherwise terminate, the Group may offer You the right to continue Coverage for a limited period of time according to State law ("State Continuation Coverage"). If You are eligible for COBRA Continuation Coverage, You may elect either COBRA continuation or State Continuation Coverage, but not both.

1. Eligibility

   You have been continuously Covered under the Group's health plan, or a health plan that the Group's health plan replaced, for at least 3 months prior to the date of the termination of Your Coverage under the Group Agreement, for any reason, except for the termination of the Group Agreement.

2. Enrolling for State Continuation Coverage

   The Group will notify Members eligible for State Continuation Coverage about how to enroll for such Coverage on or before the date their Coverage would otherwise terminate under the Group Agreement. You must request State Continuation Coverage, in writing, and pay the Premium for that Coverage, in advance, as required by the Group.

3. Premium Payment

   You must pay the monthly Premium for State Continuation Coverage to the Group at the time and place specified by the Group.

4. Coverage Provided

   Members enrolled for State Continuation Coverage will continue to be Covered under the Group Agreement and this EOC, for the remainder of the month during which Coverage under the Group Agreement would otherwise end and the greater of:

   a. 3 months; or

   b. 6 months after the end of a pregnancy that began before Your Coverage under the Group Agreement would have ended (before applying any continuation coverage); or

c. 15 months if Your Coverage under the Group Agreement would end because of divorce or the death of the Subscriber.

5. Termination of State Continuation Coverage

State Continuation Coverage will terminate upon the earliest of the following:

a. The end of the applicable period specified in subsection 4, above;

b. The end of the period for which You paid the Premium for Coverage; or

c. The termination date of the Group Agreement; or

d. The date You become eligible for coverage under another group health benefits plan; or

e. The date You become entitled to Medicare coverage.

C. Conversion Coverage

If Your Coverage under this EOC terminates for any reason other than: (1) You fail to pay a required Premium contribution; (2) You become eligible for Medicare; or (3) the Group Agreement is replaced by similar group Coverage within 31 days; You may be eligible for Conversion to Individual Coverage. This subsection does not continue Coverage under the Group Agreement. Conversion Coverage is individual health care coverage from the Plan ("Conversion Coverage").

Conversion Coverage shall be:

1. The type of individual Coverage offered to converting Members as of the date of the termination of their Coverage under the Group Agreement;

2. Issued without evidence of insurability; and

3. Effective as of the date of the termination of Your Group Coverage. The Plan shall provide an Enrollment Form and information about that Conversion Coverage upon written request from You. You must submit a completed Enrollment Form and the Premium for Conversion Coverage to the Plan, within 31 days after the termination of Your Coverage under the Group Agreement.

D. Subscriber Interplan Transfers

If You move out of Tennessee, and to an area served by another BlueCross or BlueShield Plan (the "Other Plan"), and if You have the premium bills sent to Your new address, Your Coverage will be transferred to the Plan serving Your new address. The Other Plan must offer You at least its "conversion" Plan through the Subscriber Interplan Transfer program.

The conversion Plan will provide Coverage without a medical exam or a health statement. If You accept the conversion Plan:

1. You will receive credit for the length of Your enrollment with BCBST under this Plan toward the conversion Plan's waiting periods; and

2. Any physical or mental conditions Covered by BCBST will be provided by the conversion Plan without a new waiting period, if the conversion Plan offers this Coverage to others carrying the same Plan.

However, the premium rates and benefits available from the Other Plan may vary significantly from those offered by BCBST.

The Other Plan may also offer You Coverage outside the Subscriber Transfer program. Because these additional coverages are outside the program, that Plan:

1. May require a medical exam or health statement, to exclude coverage for Pre-existing Conditions; and

2. May not apply time enrolled in Your BCBST Plan waiting periods.

E. Continued Coverage During a Family and Medical Leave Act (FMLA) Leave of Absence

Under the Family and Medical Leave Act, Subscribers may be able to take:

- up to 12 weeks of unpaid leave from employment due to certain family or medical circumstances, or
- in some instances, up to 26 weeks of unpaid leave if related to certain family members' military service related hardships.

Contact the Employer to find out if this provision applies. If it does, Members may continue health coverage during the leave, but must continue to pay the conversion options portion of the premium that the Subscriber would pay if he or she were actively working. Coverage will be subject to suspension or cancellation if the Subscriber fails to pay the premium on time. If the Subscriber takes a leave and Coverage is cancelled for any reason during that leave, Members may resume Coverage when the Subscriber returns to work without waiting for an Open Enrollment Period.

F. Continued Coverage During a Military Leave of Absence

A Subscriber may continue his or her Coverage and Coverage for his or her Dependents during military leave of absence in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994. When the Subscriber returns to work from a military leave of absence, the Subscriber will be given credit for the time the Subscriber was Covered under the Plan prior to the leave. Check with the Employer to see if this provision applies. If it does, Members may continue health coverage during the leave, but must continue to pay the conversion options portion of the premium that the Subscriber would pay if he or she were actively working. Coverage will be subject to suspension or cancellation if the Subscriber fails to pay the premium on time.

G. Continued Coverage During Other Leaves of Absence

Your Employer may allow Subscribers to continue their Coverage during other leaves of absence. Continuous coverage during such leave of absence is permitted for up to 6 months. Please check with Your human resources department to find out how long a Subscriber may take a leave of absence.

A Subscriber will also have to meet these criteria to have continuous Coverage during a leave of absence:

1. Your Employer continues to consider the Subscriber an Employee, and all other Employee benefits are continued;

2. The leave is for a specific period of time established in advance; and

3. The purpose of the leave is documented.

You may apply for Federal or State Continuation or Conversion, if the Subscriber's leave lasts longer than the permitted amount of time.

Members may continue health coverage during the leave, but must continue to pay the conversion options portion of the premium that the Subscriber would pay if he or she were actively working. Coverage will be subject to suspension or cancellation if the Subscriber fails to pay the premium on time.

Prior Authorization, Care Management, Medical Policy and Patient Safety

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

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

A. Prior Authorization

Some Covered Services must be Authorized by the Plan in advance in order to be paid at the Maximum Allowable Charge without Penalty. Obtaining Prior Authorization is not a guarantee of Coverage. All provisions of the EOC must be satisfied before Coverage for services will be provided.

Services that require Prior Authorization include, but are not limited to:

- Inpatient Hospital stays (except maternity admissions)
- Skilled nursing facility and rehabilitation facility admissions
- Certain Outpatient Surgeries and/or procedures
- Certain Specialty Drugs
- Certain Prescription Drugs (if Covered by supplemental Prescription Drug Rider)
- Advanced Radiological Imaging services
- Durable Medical Equipment (DME) greater than $500
- Spinal surgeries
- Spinal injections
- Hip, knee and shoulder surgeries
- Other services not listed at the time of printing may be added to the list of services that require Prior Authorization. Notice of changes to the Prior Authorization list will be made via Our Web site and the Member newsletter. You may also call Our customer service department at the phone number on Your ID card to find out which services require Prior Authorization.

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

Network Providers in Tennessee will request Prior Authorization for You.

You are responsible for requesting Prior Authorization when using Providers outside Tennessee and Out-of-Network Providers, or benefits will be reduced or denied.

For the most current list of services that require Prior Authorization, call customer service or visit our Web site at www.bcbst.com.

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

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

The Member is not held harmless if:

(1) A Network Provider outside Tennessee (known as a BlueCard PPO Participating Provider) fails to comply with Care Management program and Prior Authorization requirements, or

(2) An Out-of-Network Provider fails to comply with Care Management program and Prior Authorization requirements.

When You use an Out-of-Network Provider, or a Provider outside Tennessee, such as a Blue Card PPO Participating Provider, You are responsible for ensuring that the Provider obtains the appropriate Plan authorization prior to treatment. Failure to obtain the necessary authorization may result in additional Member Payments and reduced Plan payment. Contact Our customer service department for a list of Covered Services that require Prior Authorization.

B. Care Management

A number of Care Management programs are available to Members, including those with low-risk health conditions, potentially complicated medical needs, chronic illness and/or catastrophic illnesses or injuries.

Lifestyle & Health Education - Lifestyle & health education is for healthy Members and those with low-risk health conditions that can be self-managed with educational materials and tools. The program includes: (1) wellness, lifestyle and condition-specific educational materials; (2) an on-line resource for researching health topics; and (3) a toll-free number (800-656-8123) for obtaining information on more than 1,200 health-related topics.

Low Risk Case Management - Low risk case management, including disease management, is performed for Members with conditions that require a daily regimen of care. Registered nurses work with health care Providers, the Member and primary care givers to coordinate care. Specific programs include: (1) pharmacy Care Management for certain populations; (2) Emergency services management program; (3) transition of care program; (4) condition-specific care coordination program; and (5) disease management.

Catastrophic Medical and Transplant Case Management - Members with terminal illness, severe injury, major trauma, cognitive or physical disability, or Members who are transplant candidates may be served by Our catastrophic medical and transplant case management program. Registered nurses work with health care Providers, the Member, and primary caregivers to coordinate the most appropriate, cost-efficient care settings. Case managers maintain regular contact with Members throughout treatment, coordinate clinical and health plan Coverage issues, and help families utilize available community resources.

After evaluation of the Member's condition, the Plan may, at its sole discretion, determine that alternative treatment is Medically Necessary and Appropriate.

In that event, the Plan may elect to offer alternative benefits for services not otherwise specified as Covered Services in Attachment A. Such benefits will only be offered in accordance with a written case management or alternative treatment plan agreed to by the Member's attending physician and the Plan.

Emerging Health Care Programs - Care Management is continually evaluating emerging health care programs. These are processes that demonstrate potential improvement in access, quality, efficiency and Member satisfaction.

When We approve an emerging health care program, approved services provided through that program are Covered, even though they may normally be excluded under the EOC.

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

C. Medical Policy

Medical policy looks at the value of new and current medical science. Its goal is to make sure that Covered Services are safe and effective, and have proven medical value.

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

Medical policies state whether or not a technology is Medically Necessary, Investigational or cosmetic. As technologies change and improve, and as Members' needs change, We may reevaluate and change Medical Policies without formal notice. You may check Our medical policies at www.bcbst.com. Enter "medical policy" in the Search field.

Medical policies sometimes define certain terms. If the definition of a term defined in a medical policy is different from a definition in this EOC, medical policy controls.

D. Patient Safety

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

BlueCard PPO Program

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

We will help You locate the nearest BlueCard PPO Participating Provider .

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

Show Your membership ID card (that has the "PPO in a suitcase" logo) to any BlueCard PPO Participating Provider. The BlueCard PPO Participating Provider can verify Your membership, eligibility and Coverage with Your BlueCross BlueShield Plan. When You visit a BlueCard PPO Participating Provider, You should not have claim forms to file. After You receive services, Your claim is electronically routed to BCBST, which processes it and sends You a detailed explanation of benefits. You are responsible for any applicable Copayments, or Your Deductible and Coinsurance payments (if any). If We pay such amounts to a healthcare provider on Your behalf, We may collect those cost-sharing amounts directly from You.

The calculation of Your liability for claims incurred outside the BCBST service area that are processed through the BlueCard PPO program will typically be at the lower of the Provider's Billed Charges or the negotiated price BCBST pays the Host Plan.

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

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

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

REMEMBER: YOU ARE RESPONSIBLE FOR RECEIVING PRIOR AUTHORIZATION FROM BCBST. IF PRIOR AUTHORIZATION IS NOT RECEIVED, YOUR BENEFITS MAY BE REDUCED OR DENIED. CALL THE TOLL-FREE NUMBER ON YOUR MEMBERSHIP ID CARD FOR PRIOR AUTHORIZATION. IN CASE OF AN EMERGENCY, YOU SHOULD SEEK IMMEDIATE CARE FROM THE CLOSEST HEALTH CARE PROVIDER.

BLUECARD

If You don't have BLUECARD PPO (Your membership card doesn't have the "PPO in a suitcase" logo), You can go to any BlueCard Participating Provider, and receive the same level of benefits.

BLUECARD WORLDWIDE

Through the BlueCard Worldwide Program, You also have access to a participating hospital network and referrals to doctors in major travel destinations throughout the world. When You need to locate a hospital or doctor, You can call the BlueCard Worldwide Service Center at 1.800.810.BLUE, or call

collect at 1.804.673.1177, 24 hours a day, 7 days a week. You can also visit the web site https://international.mondialusa.com/bcbsa**,** or You can call BCBST. When You need inpatient medical care, call the BlueCard Worldwide Service Center, who will refer You to a participating hospital. You will only be responsible for the Plan's usual out-of-pocket expense (i.e., non-Covered expenses, Deductible, Copayment and/or Coinsurance). In an Emergency, You should go to the nearest hospital and call the BlueCard Worldwide Service Center if You are admitted. You still have the choice of using non-BlueCard Worldwide hospitals; however, You may have to pay the hospital directly and then file a claim for reimbursement. Your out-of-pocket expenses may be significantly higher. The BlueCard Worldwide Service Center will also provide referrals to doctors, but You will have to pay the Provider and then file the claim for reimbursement.

Claims and Payment

When You receive Covered Services from a Network Provider, the Provider will submit a claim to the Plan. If You receive Covered Services from an Out-of-Network Provider, either You or the Provider must submit a claim form to the Plan. We will review the claim, and let You, or the Provider, know if We need more information, before We pay or deny the claim.

A. Claims.

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

1. A pre-service claim is any claim that requires approval of a Covered Service in advance of obtaining medical care as a condition of receipt of a Covered Service, in whole or in part.

2. A post-service claim is a claim for a Covered Service that is not a pre-service claim – the medical care has already been provided to You. Only post-service claims can be billed to the Plan, or You.

3. Urgent Care is medical care or treatment that, if delayed or denied, could seriously jeopardize: (1) the life or health of the claimant; or (2) the claimant's ability to regain maximum function. Urgent Care is also medical care or treatment that, if delayed or denied, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the medical care or treatment. A claim for denied Urgent Care is always a pre-service claim.

B. Claims Billing.

1. You should not be billed or charged for Covered Services rendered by Network Providers, except for required Member Payments. The Network Provider will submit the claim directly to Us.

2. You may be charged or billed by an Out-of-Network Provider for Covered Services rendered by that Provider. If You use an Out-of-Network Provider, You are responsible for the difference between Billed Charges and the Maximum Allowable Charge for a Covered Service. You are also responsible for complying with any of the Plan's medical management policies or procedures (including obtaining Prior Authorization of such Services, when necessary).

   a. If You are charged, or receive a bill, You must submit a claim to Us.

   b. To be reimbursed, You must submit the claim within 1 year and 90 days from the date a Covered Service was received. If You do not submit a claim, within the 1 year and 90 day time period, it will not be paid. If it is not reasonably possible to submit the claim within the 1 year and 90 day time period, the claim will not be invalidated or reduced.

3. Not all Covered Services are available from Network Providers. There may be some Provider types that We do not contract with. These Providers are called Non-Contracted Providers. Claims for services received from Non-Contracted Providers are handled in the same manner as described above in 2a. and b. When using Non-Contracted providers, You are responsible for complying with any of the Plan's medical management policies or procedures including obtaining Prior Authorization of such services, when necessary.

4. You may request a claim form from Our customer service department. We will send You a claim form within 15 days. You must submit proof of payment acceptable to Us with the claim form. We may also request additional information or documentation if it is reasonably necessary to make a Coverage decision concerning a claim.

5. A Network Provider or an Out-of-Network Provider may refuse to render a service, or reduce or terminate a service that has been rendered, or require You to pay for what You believe should be a Covered Service. If this occurs:

   a. You may submit a claim to Us to obtain a Coverage decision concerning whether the Plan will Cover that service. For example, if a pharmacy (1) does not provide You with a prescribed medication; or (2) requires You to pay for that prescription, You may submit a claim to the Plan to obtain a Coverage decision about whether it is Covered by the Plan.

   b. You may request a claim form from Our customer service department. We will send You a claim form within 15 days. We may request additional information or documentation if it is reasonably necessary to make a Coverage decision concerning a claim.

6. Providers may bill or charge for Covered Services differently. Network Providers are reimbursed based on Our agreement with them. Different Network Providers have different reimbursement rates for different services. Your Out-of-Pocket expenses can be different from Provider to Provider.

C. Payment

1. If You received Covered Services from a Network Provider, We will pay the Network Provider directly. These payments are made according to the Plan's agreement with that Network Provider. You authorize assignment of benefits to that Network Provider. Covered Services will be paid at the In-Network Benefit level.

2. If You received Covered Services from an Out-of-Network Provider, You must submit, in a timely manner, a completed claim form for Covered Services. If the claim does not require further investigation, We will reimburse You. If You have not paid the Provider, We may make payment for Covered Services to either the Provider or to You, at Our discretion. Our payment fully discharges Our obligation related to that claim.

3. Non-Contracted Providers may or may not file Your claims for You. Either way, the In-Network Benefit level shown in Attachment C will apply to claims for Covered Services received from Non-Contracted Providers. However, You will be responsible for the difference in the Billed Charge and the Maximum Allowable Charge for that Covered Service. Our payment fully discharges Our obligation related to that claim.

4. If the Group Agreement is terminated, all claims for Covered Services rendered prior to the termination date, must be submitted to the Plan within 1 year and 90 days from the date the Covered Services was received.

5. We will pay benefits within 30 days after we receive a claim form that is complete. Claims are processed in accordance with current industry standards, and based on Our information at the time We receive the claim form.

6. When a claim is paid or denied, in whole or part, We will produce an Explanation of Benefits (EOB). This will describe how much was paid to the Provider, and also let You know if You owe an additional amount to that Provider. The Plan will make the EOB available to you at www.bcbst.com, or by calling the customer service department, at the number listed on Your membership ID card.

7. You are responsible for paying any applicable Copayments, Coinsurance, or Deductible amounts to the Provider. If We pay such amounts to a healthcare provider on Your behalf, We may collect those cost-sharing amounts directly from You.

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

D. Complete Information

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

Mail all claim forms to:
BlueCross BlueShield of Tennessee
Claims Service Center
1 Cameron Hill Circle, Suite 0002
Chattanooga, Tennessee 37402-0002

Coordination of Benefits

This EOC includes the following Coordination of Benefits (COB) provision that applies when a Member has coverage under more than one group contract or health care "Plan." A COB provision is one that is intended to avoid claims payment delays, to aid in prompt payment, and avoid duplication of benefits.

Rules of this Section determine whether the benefits available under this EOC are determined before or after those of another Plan. In no event, however, will benefits under this EOC, or the Group Agreement, be increased because of this provision. The benefits under this EOC may be reduced when another Plan determines its benefits first.

If this COB provision applies, the order of benefits determination rules should be looked at first. Those rules determine whether the benefits of this Plan are determined before or after those of another Plan.

1. Definitions

   The following terms apply to this provision:

   a. "Plan" means any form of medical or dental coverage with which coordination is allowed. "Plan" includes:

      (1) Group, blanket, or franchise insurance;

      (2) A group BlueCross Plan, BlueShield Plan;

      (3) Group or group-type coverage through HMOs or other prepayment, group practice and individual practice plans;

      (4) Coverage under labor management trust Plans or employee benefit organization Plans;

      (5) Coverage under government programs to which an employer contributes or makes payroll deductions;

      (6) Coverage under a governmental Plan or coverage required or provided by law;

      (7) Medical benefits coverage in group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts;

      (8) Coverage under Medicare and other governmental benefits; and

      (9) Any other arrangement of health coverage for individuals in a group.

   b. "Plan" does not include individual (or the individual's family)

      (1) Insurance contracts;

      (2) Subscriber contracts;

      (3) Coverage through Health Maintenance (HMO) organizations;

      (4) Coverage under other prepayment, group practice and individual practice plans;

      (5) Public medical assistance programs (such as TennCare[sm]);

      (6) Group or group-type hospital indemnity benefits of $100 per day or less;

      (7) School accident-type coverages.

      Each Contract or other arrangement for coverage is a separate Plan. Also, if an arrangement has two parts and COB rules apply to only one of the two, each of the parts is a separate Plan.

c. "This Plan" refers to the part of the Group Agreement under which benefits for health care expenses are provided.

The term "Other Plan" applies to each arrangement for benefits or services, as well as any part of such an arrangement that considers the benefits and services of other Contracts when benefits are determined.

d. Primary Plan/Secondary Plan.

(1) The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering You.

(2) When This Plan is a Primary Plan, its benefits are determined before those of the Other Plan. We do not consider the Other Plan's benefits.

(3) When This Plan is a Secondary Plan, its benefits are determined after those of the Other Plan and may be reduced because of the Other Plan's benefits.

(4) When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more Other Plans, and may be a Secondary Plan as to a different Plan or Plans.

e. "Allowable Expense" means a necessary, reasonable and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the Member for whom the claim is made.

(1) When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense, and a benefit paid.

(2) The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense under the above definition, unless the patient's stay in a private hospital room is Medically Necessary, either in terms of generally accepted medical practice, or as specifically defined in the Plan.

(3) We will determine only the benefits available under This Plan. You are responsible for supplying Us with information about Other Plans so We can act on this provision.

f. "Claim Determination Period" means an Annual Benefit Period. However, it does not include any part of a year during which You have no Coverage under This Plan, or any part of a year prior to the date this COB provision or a similar provision takes effect.

2. Order of Benefit Determination Rules

This Plan determines its order of benefits using the first of the following rules that applies:

a. Non-Dependent/Dependent

The benefits of the Plan that covers the person as an Employee, Member, or Subscriber (that is, other than as a Dependent) are determined before those of the Plan that covers the person as a Dependent, except that:

(1) if the person is also a Medicare beneficiary and,

(2) if the rule established by the Social Security Act of 1965 (as amended) makes Medicare secondary to the Plan covering the person as a Dependent of an active Employee, then the order of benefit determination shall be:

- benefits of the Plan of an active Employee covering the person as a Dependent;
- Medicare;
- benefits of the Plan covering the person as an Employee, Member, or Subscriber.

b. Dependent Child/Parents Not Separated or Divorced

Except as stated in Paragraph c. below, when This Plan and another Plan cover the same child as a Dependent of different persons, called "parents:"

(1) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but

(2) If both parents have the same birthday, the benefits of the Plan that covered the parent longer are determined before those of the Plan that covered the other parent for a shorter period of time.

(3) However, if the Other Plan does not have the rule described immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the Other Plan will determine the order of benefits.

c. Dependent Child/Separated or Divorced Parents

If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

(1) First, the Plan of the parent with custody of the child;

(2) Then, the Plan of the spouse of the parent with the custody of the child; and

(3) Finally, the Plan of the parent not having custody of the child.

(4) However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(5) If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined above, Dependent Child/Parents Not Separated or Divorced.

d. Active/Inactive Employee

The benefits of a Plan that covers a person as an Employee who is neither laid off nor retired (or as that Employee's dependent), are determined before those of a Plan that covers that person as a laid off or retired Employee (or as that Employee's dependent). If the Other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Rule is ignored, and other applicable rules control the order of benefit determination.

e. Longer/Shorter Length of Coverage

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 that has covered that person for the shorter term.

(1) To determine the length of time a person has been covered under a Plan, two Plans shall be treated as one if the claimant was eligible under the second within twenty-four hours after the first ended.

(2) The start of the new Plan does not include:

- A change in the amount or scope of a Plan's benefits;
- A change in the entity that pays, provides, or administers the Plan's benefits; or
- A change from one type of Plan to another (such as, from a single Employer Plan to that of a multiple Employer plan).

(3) The claimant's length of time covered under a Plan is measured from the claimant's first date of coverage under that Plan. If that date is not readily available, the date the claimant first became a Member of the Group shall be used as the date from which to determine the length of time the claimant's coverage under the present Plan has been in force.

f. Plans with Excess and Other Non-conforming COB Provisions

Some Plans declare their coverage "in excess" to all Other Plans, "always Secondary," or otherwise not governed by COB rules. These Plans are called "Non-complying Plans."

This Plan coordinates its benefits with a Non-complying Plan as follows:

(1) If This Plan is the Primary Plan, it will provide its benefits on a primary basis.

(2) If This Plan is the Secondary Plan, it will provide benefits first, but the amount of benefits and liability of This Plan will be limited to the benefits of a Secondary Plan.

(3) If the Non-complying Plan does not provide information needed to determine This Plan's benefits within a reasonable time after it is requested, This Plan will assume that the benefits of the Non-complying Plan are the same as the benefits of This Plan and provide benefits accordingly. However, this Plan must adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the Non-complying Plan.

(4) If:

(a) The Non-complying Plan reduces its benefits so that the Employee, Subscriber or Member receives less in benefits than he or she would have received had the Complying Plan paid, or provided its benefits as the Secondary Plan, and the Non-complying Plan paid or provided its benefits as the Primary Plan; and

(b) Governing state law allows the right of subrogation set forth below;

then the Complying Plan shall advance to You, or on Your behalf, an amount equal to such difference. However, in no event shall the Complying Plan advance more than the Complying Plan would have paid, had it been the Primary Plan, less any amount it previously paid. In consideration of such advance, the Complying Plan shall be subrogated to all Your rights against the Non-complying Plan. Such advance by the Complying Plan shall also be without prejudice it may have against the Non-complying Plan in the absence of such subrogation.

3. Effect on the Benefits of this Plan

This provision applies where there is a basis for a claim under This Plan and the Other Plan and when benefits of This Plan are determined as a Secondary Plan.

a. Benefits of This Plan will be reduced when the sum of:

(1) The benefits that would be payable for the Allowable Expenses under This Plan, in the absence of this COB provision; and

(2) The benefits that would be payable for the Allowable Expenses under the Other Plan(s), in the absence of provisions with a purpose similar to that of this COB provision, whether or not a claim for benefits is made;

exceeds Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the Other Plan(s) do not total more than Allowable Expenses.

b. When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion, and is then charged against any applicable benefit limit of This Plan.

4. Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. We have the right to decide which facts We need. We may get needed facts from, or give them to any other organization or person. We need not tell, or get the consent of, any person, to do this. Each person claiming benefits under This Plan must give Us any facts We need to pay the claim.

5. Facility of Payment

A payment under Another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount would then be treated as if it were a benefit paid under This Plan. We will not have to pay that amount again. The term, "Payment Made", includes providing benefits in the form of services; in which case, Payment Made means reasonable cash value of the benefits provided in the form of services.

6. Right of Recovery

If the amount of the payments made by the Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:

(1) The persons it has paid or for whom it has paid;

(2) Insurance companies; or

(3) Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

7. Are You Also Covered by Medicare?

If You are also Covered by Medicare, We follow the Medicare Secondary Payor (MSP) rules to determine Your benefits. If Your Employer has 20 or fewer employees, the MSP rules might not apply. Please contact customer service at the toll free number on Your membership ID card if You have any questions.

Grievance Procedure

I. INTRODUCTION

Our Grievance procedure (the "Procedure") is intended to provide a fair, quick and inexpensive method of resolving any and all Disputes with the Plan. Such Disputes include: any matters that cause You to be dissatisfied with any aspect of Your relationship with the Plan; any Adverse Benefit Determination concerning a Claim; or any other claim, controversy, or potential cause of action You may have against the Plan.

Adverse Benefit Determination means:

A. A determination by a health carrier or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health carrier's health benefit plan does not meet the health carrier's requirements for medical necessity, appropriateness, healthcare setting, level of care or effectiveness and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit;

B. The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier of a covered person's eligibility to participate in the health carrier's health benefit plan; or

C. Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment for, in whole or in part, a benefit.

Please contact the customer service department at the number listed on Your membership ID card: (1) to file a Claim; (2) if You have any questions about this EOC or other documents related to Your Coverage (e.g. an explanation of benefits or monthly claims statement); or (3) to initiate a Grievance concerning a Dispute.

1. This Grievance Procedure must be exhausted as required by ERISA. However, nothing in this EOC shall prevent You from filing a complaint with the Tennessee Department of Commerce and Insurance, but such complaint is outside of, separate from, and in addition to this Grievance Procedure.

2. The Procedure can only resolve Disputes that are subject to Our control.

3. You cannot use this Procedure to resolve a claim that a Provider was negligent. Network Providers are independent contractors. They are solely responsible for making treatment decisions in consultation with their patients. You may contact the Plan, however, to complain about any matter related to the quality or availability of services, or any other aspect of Your relationship with Providers.

4. Under this Procedure:

   a. If a Provider does not render a service, or reduces or terminates a service that has been rendered, or requires You to pay for what You believe should be a Covered Service, You may submit a Claim to the Plan to obtain a determination concerning whether the Plan will cover that service. As an example, if a pharmacy does not provide You with a prescribed medication or requires You to pay for that prescription, You may submit a Claim to the Plan to obtain a determination about whether it is Covered by the Plan. Providers may be required to hold You harmless for the cost of services in some circumstances.

   b. Providers may also appeal an Adverse Benefit Determination through the Plan's Provider dispute resolution procedure.

c. A Plan determination will not be an Adverse Benefit Determination if: (1) a Provider is required to hold You harmless for the cost of services rendered; or (2) until the Plan has rendered a final Adverse Benefit Determination in a matter being appealed through the Provider dispute resolution procedure.

5. You may request a form from the Plan to authorize another person to act on Your behalf concerning a Dispute.

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

7. Any Dispute will be resolved in accordance with applicable Tennessee or Federal laws and regulations, the Group Agreement and this EOC.

II. DESCRIPTION OF THE REVIEW PROCEDURES

A. Inquiry

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

B. Grievance

You must submit a written request asking the Plan to reconsider an Adverse Benefit Determination, or take a requested action to resolve another type of Dispute (Your "Grievance"). You must begin the Dispute process within 180 days from the date We issue notice of an Adverse Benefit Determination from the Plan or from the date of the event that is otherwise causing You to be dissatisfied with the Plan. If You do not initiate a Grievance within 180 days of when We issue an Adverse Benefit Determination, You may give up the right to take any action related to that Dispute. The Grievance process that was in effect on the date(s) of service for which you received an Adverse Benefit Determination will apply.

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

1. Grievance Hearing

After the Plan has received and reviewed Your Grievance, Our first level Grievance committee will meet to consider Your Grievance and any additional information that You or others submit concerning that Grievance. In Grievances concerning urgent care or pre-service Claims, the Plan will appoint one or more qualified reviewer(s) to consider such Grievances. Individuals involved in making prior determinations concerning Your Dispute are not eligible to be voting members of the first level Grievance committee or reviewers. The Committee or reviewers have full discretionary authority to make eligibility, benefit and/or claim determinations, pursuant to the Group Agreement. Such determinations shall be subject to the review standards applicable to ERISA plans, even if the Group Agreement is not otherwise governed by ERISA.

2. Written Decision

The committee or reviewers will consider the information presented, and You will receive a written decision concerning Your Grievance as follows:

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

(b) For a post-service claim, within 60 days of receipt of Your request for review; and

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

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

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

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

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

C. Second Level Grievance Procedure

You may file a written request for reconsideration within 90 days after We issue the first level Grievance committee's decision. This is called a second level Grievance. Information on how to submit a second level Grievance will be provided to You in the decision letter following the first level Grievance review.

If Your Group Agreement is governed by ERISA, You also have the right to bring a civil action against the Plan to obtain the remedies available pursuant to Sec. 502(a) of ERISA ("ERISA Actions") after completing the mandatory first level Grievance process.

The Plan may require You to exhaust each step of this Procedure in any Dispute that is not an ERISA Action.

Your decision concerning whether to file a second level Grievance has no effect on Your rights to any other benefits under the Plan. If You file a second level Grievance concerning an ERISA Action, We agree to toll any time defenses or restrictions affecting Your right to bring a civil action against the Plan until the second level committee makes its decision. Any person involved in making a decision concerning Your Dispute (e.g. first level committee members) will not be a voting member of the second level Grievance committee.

1. Grievance Hearing

You may request an in-person or telephonic hearing before the second level Grievance committee. You may also request that the second level Grievance committee reconsider the decision of the first level committee, even if You do not want to participate in a hearing concerning Your Grievance. If You wish to participate, Our representatives will contact You to explain the hearing process and schedule the time, date and place for that hearing.

In either case, the second level committee will meet and consider all relevant information presented about Your Grievance, including:

(a) Any new, relevant information that You submit for consideration; and

(b) Information presented during the hearing. Second level Grievance committee members may ask You questions during the hearing. You may make a closing statement to the committee at the end of the hearing.

(c) If You wish to bring a personal representative with You to the hearing, You must notify Us at least 5 days in advance and provide the name, address and telephone number of Your personal representative.

2. Written Decision

After the hearing, the second level committee will meet in closed session to make a decision concerning Your Grievance. That decision will be sent to You in writing. The written decision will contain:

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

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

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

D. Independent Review of Medical Necessity Determinations or Coverage Rescissions

If Your Grievance involves a Medical Necessity determination or a Coverage rescission determination, then either: (1) after completion of the mandatory first level Grievance; or (2) after completion of the mandatory first level Grievance immediately followed by completion of the second level Grievance, You may request that the Dispute be submitted to a neutral third party, selected by the Plan, to independently review and resolve such Dispute(s). If You request an independent review following the mandatory first level Grievance, You waive Your right to a second level Grievance and Your right to present testimony during the Grievance Procedure. Your request for independent review must be submitted in writing within 180 days after the date You receive notice of the committee's decision. Receipt shall be deemed to have occurred no more than two days after the date of issuance of the committee's decision. Any person involved in making a decision concerning Your Dispute will not be a voting member of the independent review panel or committee.

Your decision concerning whether to request independent review has no effect on Your rights to any other benefits under the Plan. If You request independent review of an ERISA Action, We agree to toll any time defenses or restrictions affecting Your right to bring a civil action against the Plan, until the independent reviewer makes its decision.

The Plan will pay the fee charged by the independent review organization and its reviewers if You request that the Plan submit a Dispute to independent review. You will be responsible for any other costs that You incur to participate in the independent review process, including attorney's fees.

The Plan will submit the necessary information to the independent review entity within 5 business days after receiving Your request for review. The Plan will provide copies of Your file, excluding any proprietary information to You, upon written request. The reviewer may also request additional medical information from You. You must submit any requested information, or explain why that information is not being submitted, within 5 business days after receiving that request from the reviewer.

The reviewer must submit a written determination to the Plan and You within 45 days after receipt of the independent review request. In the case of a life threatening condition, the decision must be issued within 72 hours after receiving the review request. Except in cases involving a life-threatening condition, the reviewer may request an extension of up to 5 business days to issue a determination to consider additional information submitted by the Plan or You.

The reviewer's decision must state the reasons for the determination based upon: (1) the terms of this EOC and the Group Agreement; (2) Your medical condition; and (3) information submitted to the reviewer. The reviewer's decision may not expand the terms of Coverage of the Group Agreement.

No action at law or in equity shall be brought to recover on this EOC until 60 days after a claim has been filed as required by this EOC. No such action shall be brought beyond 3 years after the time the claim is required to be filed.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

LEGAL OBLIGATIONS

BlueCross BlueShield of Tennessee, Inc. is required to maintain the privacy of all medical information as required by applicable laws and regulations (hereafter referred to as our "legal obligations"); provide this notice of privacy practices to all Members; inform Members of the Plan's legal obligations; and advise Members of additional rights concerning their medical information. The Plan must follow the privacy practices contained in this notice from its effective date of April 14, 2003, until this notice is changed or replaced.

The Plan reserves the right to change privacy practices and the terms of this notice at any time, as permitted by the Plan's legal obligations. Any changes made in these privacy practices will be effective for all medical information that is maintained including medical information created or received before the changes are made. All Members will be notified of any changes by receiving a new notice of the Plan's privacy practices.

You may request a copy of this notice of privacy practices at any time by contacting BlueCross BlueShield of Tennessee, Privacy Office, 1 Cameron Hill Circle, Chattanooga, TN 37402.

ORGANIZATIONS COVERED BY THIS NOTICE

This notice applies to the privacy practices of BlueCross BlueShield of Tennessee and its subsidiaries or affiliated covered entities. Medical information about the Plan's Members may be shared with each other as needed for treatment, payment or health care operations.

USES AND DISCLOSURES OF MEDICAL INFORMATION

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

TREATMENT: Your medical information may be disclosed to a doctor or hospital that asks for it to provide treatment to You.

PAYMENT: Your medical information may be used or disclosed to pay claims for services, which are Covered under Your health insurance policy.

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

AUTHORIZATIONS: You may provide written authorization to use Your medical information or to disclose it to anyone for any purpose. You may revoke Your authorization in writing at any time. That revocation will not affect any use or disclosure permitted by Your authorization while it was in effect. We cannot use or disclose Your medical information for any reason except those described in this notice, without Your written authorization.

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

PLAN SPONSORS: Your medical information and the medical information of others enrolled in Your group health plan may be disclosed to Your plan sponsor in order to perform plan

administration functions. Please see Your plan documents for a full description of the uses and disclosures the plan sponsor may make of Your medical information in such circumstances.

UNDERWRITING: Your medical information may be received for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a health insurance or benefits contract. If the Plan does not issue that contract, Your medical information will not be used or further disclosed for any other purpose, except as required by law.

MARKETING: Your medical information may be used to provide information about health-related benefits, services or treatment alternatives that may be of interest to You. Your medical information may be disclosed to a business associate assisting us in providing that information to You. You may opt-out of receiving further information (see the instructions for opting out at the end of this notice), unless the information is provided to You in a newsletter or in person or concerns products or services of nominal value.

RESEARCH: The Plan's legal obligations permit Your medical information to be used or disclosed for research purposes. If You die, Your medical information may be disclosed to a coroner, medical examiner, funeral director or organ procurement organization.

AS REQUIRED BY LAW: Your medical information may be used or disclosed as required by state or federal laws.

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

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

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

INDIVIDUAL RIGHTS

You have the right to look at or get copies of Your medical information, with limited exceptions. You must make a written request, using a form available from the Privacy Office, to obtain access to Your medical information. If You request copies of Your medical information, we will charge $.25 per page, $10 per hour for staff time required to copy that information, and postage if You want the copies mailed to You. If You request an alternative format, the charge will be based upon the Plan's cost of providing Your medical information in that format. If You prefer, the Plan will prepare a summary or explanation of Your medical information for a fee. For a more detailed explanation of the fee structure, please contact the Privacy Office. The Plan will require advance payment before copying Your medical information.

You have the right to receive an accounting of any disclosures of Your medical information made by the Plan or a business associate for any reason, other than treatment, payment, health care operations purposes after April 14, 2003. This accounting will include the date the disclosure was made, the name of the person or entity the disclosure was made to, a description of the medical information disclosed the reason for the disclosure, and certain other information. If You request an accounting more than once in a 12-month period, there may be a reasonable cost-based charge for responding to those additional requests. Please contact the Privacy Office for a more detailed explanation of the fees charged for such accountings.

You have the right to request restrictions on the Plan's use or disclosure of Your medical information the Plan is not required to agree to such requests. **The Plan will only restrict the use or disclosure of Your medical information as set forth in a written agreement that is signed by a representative of the Privacy Office on behalf of BlueCross BlueShield of Tennessee.**

If You reasonably believe that sending confidential medical information to You in the normal manner will endanger You, You have the right to make a written request the Plan communicates that information to You by a different method or to a different address. **If there is an immediate threat, You may make that request by calling a consumer advisor or The Privacy Officer at 1-888-455-3824 and follow up with a written request when feasible.** The Plan must accommodate Your request if it is reasonable, specifies how and where to communicate with You, and continues to permit us to collect premium and pay claims under Your health plan.

You have the right to make a written request that the Plan amends Your medical information. **Your request must explain why the information should be amended.** The Plan may deny Your request if the medical information You seek to amend was not created by the Plan or for other reasons permitted by the Plan's legal obligations. If Your request is denied, the Plan will provide a written explanation of the denial. If You disagree, You may submit a written statement that will be included with Your medical information. If the Plan accepts Your request, the Plan will make reasonable efforts to inform the people that You designate about that amendment and will amend any future disclosures of that information.

If you receive this notice on our web site or by electronic mail (e-mail), You may request a written copy of this notice, by contacting the Privacy Office.

QUESTIONS AND COMPLAINTS

If You want more information concerning the companies' privacy practices or have questions or concerns, please contact the Privacy Office.

If:

1. You are concerned that the Plan has violated Your privacy rights; or
2. You disagree with a decision made about access to Your medical information or in response to a request You made to amend or restrict the use or disclosure of Your medical information; or
3. You wish to request the Plan communicate with You by alternative means or at alternative locations;

please contact the Privacy Office.

You may also submit a written complaint to the U.S. Department of Health and Human Services. The Plan will furnish the address where You can file a complaint with the U.S. Department of Health and Human Services upon request.

We support Your right to protect the privacy of Your medical information. There will be no retaliation in any way if You choose to file a complaint with us or with the U.S. Department of Health and Human Services.

The Privacy Office
BlueCross BlueShield of Tennessee, Inc.
1 Cameron Hill Circle
Chattanooga, TN 37402
(888) 455-3824
(423) 535-1976 FAX
Privacy_office@bcbst.com

General Legal Provisions

The Plan is an Independent Licensee of the BlueCross BlueShield Association

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

Relationship With Network Providers

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

The Plan has the discretionary authority to make benefit or eligibility determinations and interpret the terms of Your Coverage to the Plan ("Coverage Decisions"). It makes those Coverage Decisions based on the terms of this EOC, the Group Agreement, its participation agreements with Network Providers and applicable State or Federal laws.

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

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

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., Your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce Your Out of-Pocket costs, You may be required to obtain precertification. For information on precertification, contact Your plan administrator.

Women's Health and Cancer Rights Act of 1998

Patients who undergo a mastectomy, and who elect breast reconstruction in connection with the mastectomy, are entitled to coverage for

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas

in a manner determined in consultation with the attending physician and the patient. The coverage may be subject to coinsurance and deductibles consistent with those established for other benefits. Please refer to the body of the EOC for details.

Notice Regarding Certificates of Creditable Coverage

This Plan contains a Pre-Existing Condition exclusion that may limit Your Coverage. The Pre-Existing Condition Waiting Period for any Pre-Existing Condition will be reduced by the total amount of time You were covered by similar creditable health coverage, unless Your coverage was interrupted for more than 63 days. Periods of similar creditable health coverage prior to a break in coverage of 63 days or more shall not be deducted from the Pre-Existing Condition Waiting Period. Any period of time You had to wait to be eligible under an employer's plan is not considered an interruption of coverage.

You have the right to demonstrate the amount of Creditable Coverage You have, including any waiting periods that were applied before You became eligible for Coverage. For any period after July 1, 1996, You can ask a plan sponsor, health insurer or HMO to provide you with a "certification form" documenting the periods during which You had health benefit coverage. If You are having trouble obtaining documentation of Your prior Creditable Coverage, You may contact the Plan for assistance in obtaining documentation of prior Creditable Coverage from any prior plan or issuer.

If You lose eligibility for Coverage under this Plan, We will send You a Certificate of Creditable Coverage at Your last address on file with Us.

Uniformed Services Employment and Reemployment Rights Act of 1994

A Subscriber may continue his or her Coverage and Coverage for his or her Dependents during military leave of absence in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994. When the Subscriber returns to work from a military leave of absence, the Subscriber will be given credit for the time the Subscriber was Covered under the Plan prior to the leave. Check with the Employer to see if this provision applies.

Governing Laws

Tennessee laws govern Your benefits; however, if the extraterritorial laws of another state apply to Your benefits, We will administer Your benefits accordingly.

Subrogation and Right of Recovery

The Group has agreed that the Plan shall be subrogated to and/or have the right to recover amounts paid to provide Covered Services to Group Members for illnesses or injuries caused by third parties, including the right to recover the reasonable value of services rendered by Network Providers.

The Plan shall have first lien against any payment, judgment or settlement of any kind that a Member receives from or on behalf of such third parties for medical expenses, for the costs of Covered Services and any costs of recovering such amounts from those third parties. The Plan may notify those parties of its lien without notice to or consent from those Members.

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

The Group has agreed that Members shall be required to promptly notify the Plan if they are involved in an incident that gives rise to such rights for subrogation and recovery to enable the Plan to protect its rights under this section. Members are also required to cooperate with the Plan and to execute any documents that the Plan deems necessary to protect its rights under this section.

If a Member settles any claim or action against any third party without Our consent, that Member shall be deemed to have been made whole by the settlement and the Plan shall be entitled to immediately collect the present value of its rights as the first priority claim from the settlement fund. Any such proceeds of settlement or judgment shall be held in trust by the Member for the benefit of the Plan. The Plan shall also be entitled to recover reasonable attorneys' fees incurred in collecting proceeds held by the Member in such circumstances.

Definitions

Defined terms are capitalized. When defined words are used in this EOC, they have the meaning set forth in this section. Words that are defined in the Plan's Medical Policies and Procedures have the same meaning if used in this EOC.

1. **Actively At Work -** The performance of all of an Employee's regular duties for the Group on a regularly scheduled workday at the location where such duties are normally performed. An Employee will be considered to be Actively At Work on a non-scheduled work day (which would include a scheduled vacation day) only if he or she was Actively At Work on the last regularly scheduled work day.

2. **Acute -** An illness or injury that is both severe and of short duration.

3. **Advanced Radiological Imaging** – Services such as MRIs, MRAs, CAT scans, CT scans, PET scans, nuclear medicine and similar technologies.

4. **Annual Benefit Period** - The 12-month period under which Your benefits are administered, as noted in Attachment C: Schedule of Benefits.

5. **Behavioral Health Services** - Any services or supplies that are Medically Necessary and Appropriate to treat: a mental or nervous condition; alcoholism; chemical dependence; drug abuse or drug addiction.

6. **Billed Charges** – The amount that a Provider charges for services rendered. Billed Charges may be different from the amount that BCBST determines to be the Maximum Allowable Charge for services.

7. **BlueCard PPO Participating Provider** – A physician, hospital, licensed skilled nursing facility, home health care Provider or other Provider contracted with other BlueCross and/or BlueShield Plans, Blue Card PPO Plans and/or Authorized by the Plan to provide Covered Services to Members.

8. **Care Management** – A program that promotes cost effective coordination of care for Members with complicated medical needs, chronic illnesses, and/or catastrophic illnesses or injuries.

9. **CHIP** – The State Children's Health Insurance Program established under title XXI of the Social Security Act (42 U.S.C. 1396 et. seq.)

10. **Coinsurance** – Sharing of the cost of Covered Services by the Plan and You, after Your Deductible has been satisfied. The Plan's Coinsurance amounts for in-network and out-of-network Covered Services are specified in Attachment C: Schedule of Benefits. Your Coinsurance is calculated as 100% minus the Plan's Coinsurance. In addition to Your Coinsurance, You are responsible for the difference between the Billed Charge and the Maximum Allowable Charge for Covered Services if the Billed Charge of an Out-of-Network Provider is more than the Maximum Allowable Charge for such services.

    Coinsurance applies to the Maximum Allowable Charge for Covered Services. For example, if the Out-of-Network Provider's Billed Charge is $5,000 and the Maximum Allowable Charge for Network Providers is $3,000, the Coinsurance percentage is based upon $3,000, not $5,000. In this example, You are responsible for the $2,000 charge difference plus Your Coinsurance on the $3,000 Maximum Allowable Charge.

11. **Complications of Pregnancy** – Conditions requiring Hospital Confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or caused by pregnancy, such as Acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, non-elective cesarean section, ectopic pregnancy that is terminated, and spontaneous

termination of pregnancy, that occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy does not include false labor; occasional spotting; physician prescribed rest during the period of pregnancy; morning sickness; hyperemesis gravidarum and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

12. **Concurrent Review** – The process of evaluating care during the period when Covered Services are being rendered.

13. **Copayment** – The dollar amount specified in Attachment C: Schedule of Benefits, that You are required to pay directly to a Provider for certain Covered Services. You must pay such Copayments at the time You receive those Services.

14. **Cosmetic Service** – Any surgical or non-surgical treatment, drugs or devices intended to alter or reshape the body for the purpose of improving appearance or self-esteem. Our Medical Policy establishes the criteria for what is cosmetic, and what is Medically Necessary and Appropriate.

15. **Covered Dependent** - A Subscriber's family members who: (1) meet the eligibility requirements of this EOC, (2) have been enrolled for Coverage; and (3) for whom the Plan has received the applicable Premium for Coverage.

16. **Covered Family Members** – A Subscriber and his or her Covered Dependents.

17. **Covered Services, Coverage or Covered** - Those Medically Necessary and Appropriate services and supplies that are set forth in Attachment A of this EOC, (that is incorporated by reference). Covered Services are subject to all the terms, conditions, exclusions and limitations of the Group Agreement and this EOC.

18. **Creditable Coverage** – Credit for Your individual or group health coverage prior to Your Enrollment Date that may be applied to reduce Your Pre-existing Condition Waiting Period, if any, stated in this EOC. Creditable Coverage includes coverage under: (1) a group health plan; (2) health insurance coverage; (3) health maintenance organization (HMO); (4) Medicare; (5) Medicaid (including TennCare℠ and TennCare Select℠); (6) COBRA continuation and state continuation; (7) the Federal Employee Health Benefit Plan; (8) a public, government, military or Indian Health Service health benefit program and/or (9) State Children's Health Insurance Program (S-CHIP).

    Up to 18 months of Creditable Coverage may be applied to reduce Your applicable Pre-existing Condition Waiting Period. However, a period of coverage will not be counted for purposes of reducing Your Pre-existing Condition Waiting Period if there is a break in such coverage of 63 days or more during which You were not covered under any Creditable Coverage.

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

20. **Deductible** - The dollar amount, specified in Attachment C: Schedule of Benefits that You must incur and pay for Covered Services during an Annual Benefit Period before the Plan provides benefits for services. If a claim includes dates of service that span two Annual Benefit Periods, benefits may be subject to a Deductible for each Annual Benefit Period. There are 2 separate Deductible amounts – one for Network Providers and one for Out-of-Network Providers. The Deductible will apply to the Out-of-Pocket Maximum(s).

Copayments and any balance of charges (the difference between Billed Charges and the Maximum Allowable Charge) are not considered when determining if You have satisfied a Deductible.

21. **Effective Date -** The date Your Coverage under this EOC begins.

22. **Eligible Providers -** All services must be rendered by a Practitioner or Provider type listed in the Plan's Provider Directory of Network Providers, or as otherwise required by Tennessee law. The services provided by a Practitioner must be within his or her specialty or degree. All services must be rendered by the Practitioner or Provider, or the delegate actually billing for the Practitioner or Provider, and be within the scope of his or her licensure.

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

    a. serious impairment of bodily functions; or

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

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

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

24. **Emergency Care Services -** Those services and supplies delivered in a hospital emergency department that are Medically Necessary and Appropriate in the treatment of an Emergency.

25. **Employee -** A person who fulfills all eligibility requirements established by the Group and the Plan.

26. **Enrollment Form** – A form or application that must be completed in full by the eligible Employee before he/she will be considered for Coverage under the Plan. Your Group may have You use an electric form to enroll, rather than a paper form.

27. **ERISA -** The Employee Retirement Income Security Act of 1974, as amended.

28. **Group Agreement or Agreement** – The arrangements between the Plan and the Group, including this EOC, the Employer Group Application, any Riders, any amendments, and any attachments to the Agreement or this EOC. If there is any conflict between the Group Agreement and this EOC, the Group Agreement shall be controlling.

29. **Group or Employer** – A corporation, partnership, union or other entity that is eligible for Group Coverage under State and Federal laws, and the Plan's Underwriting Guidelines; and that enters into an Agreement with the Plan to provide Coverage to its Employees and their eligible Dependents.

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

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

32. **In-Network Benefit –** The Plan's payment level that applies to Covered Services received from a Network Provider. See Attachment C: Schedule of Benefits.

33. **In-Transplant Network Institution** – A facility or hospital that has contracted with BCBST (or with an entity on behalf of BCBST) to provide Transplant Services for some or all organ and bone marrow transplant procedures Covered under this Plan. For example, some hospitals might contract to perform heart transplants, but not liver transplants. An In-Transplant Network

Institution is a Network Provider when performing contracted transplant procedures in accordance with the requirements of this EOC.

34. **Incapacitated Child** – an unmarried child who is, and continues to be, both (1) incapable of self-sustaining employment by reason of intellectual disabilities (excluding mental illness) or physical handicap; and (2) chiefly dependent upon the Subscriber or Subscriber's spouse for economic support and maintenance.

    a. If the child reaches this Plan's limiting age while Covered under this Plan, proof of such incapacity and dependency must be furnished within 31 days of when the child reaches the limiting age.

    b. Incapacitated dependents of Subscribers of new groups, or of Subscribers who are newly eligible under this Plan, are eligible for Coverage if they were covered under the Subscriber's or the Subscriber's spouse's previous health benefit plan, and have less than a 63 day break in coverage from the prior plan. We may ask You to furnish proof of the incapacity and dependency upon enrollment.

    We may ask for proof that the child continues to meet the conditions of incapacity and dependency, but not more frequently than annually.

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

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

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

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

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

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

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

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

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

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

    (1) Your medical records, or

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

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

(4) the published authoritative medical or scientific literature regarding the proposed service or supply in connection with the treatment of injuries or illnesses such as those experienced by You, or

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

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

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

36. **Late Enrollee** – An Employee or eligible Dependent who fails to apply for Coverage within: (1) 31 days after such person first became eligible for Coverage under this EOC; or (2) within a subsequent Open Enrollment Period.

37. **Maintenance Care** – Medical services (including skilled services and therapies), prescription drugs, supplies and equipment for chronic, static or progressive medical conditions where the medical services (including skilled services and therapies), drugs, supplies and equipment: (1) fail to contribute toward cure; (2) fail to improve unassisted clinical function; (3) fail to significantly improve health; and (4) are indefinite or long-term in nature. This exclusion also applies to drugs used to treat chemical dependency.

38. **Maximum Allowable Charge** – The amount that the Plan, at its sole discretion, has determined to be the maximum amount payable for a Covered Service. That determination will be based upon the Plan's contract with a Network Provider for Covered Services rendered by that Provider or the amount payable based on the Plan's fee schedule for the Covered Services for Services rendered by Out-of-Network Providers.

39. **Medicaid** – The program for medical assistance established under title XIX of the Social Security Act (42 U.S.C. 1396 et. seq.)

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

41. **Medically Appropriate** – Services that have been determined by the Medical Director of the Plan to be of value in the care of a specific Member. To be Medically Appropriate a service must:

    a. be Medically Necessary;

    b. be used to diagnose or treat a Member's condition caused by disease, injury or congenital malformation;

    c. be consistent with current standards of good medical practice for the Member's medical condition;

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

    e. on an ongoing basis, have a reasonable probability of:

        (1) correcting a significant congenital malformation or disfigurement caused by disease or injury.

(2) preventing significant malformation or disease.

(3) substantially improving a life sustaining bodily function impaired by disease or injury.

f. not be provided solely to improve a Member's condition beyond normal variations in individual development and aging including:

(1) comfort measures in the absence of disease or injury.

(2) Cosmetic Service.

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

42. **Medically Necessary or Medical Necessity** – "Medically Necessary" means procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical Practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

a. in accordance with generally accepted standards of medical practice; and

b. clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and

c. not primarily for the convenience of the patient, physician or other health care Provider; and

d. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and the views of medical Practitioners practicing in relevant clinical areas and any other relevant factors.

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

44. **Member, You, Your** - Any person enrolled as a Subscriber or Covered Dependent under a Group Agreement.

45. **Member Payment** – The dollar amounts for Covered Services that You are responsible for as set forth in Attachment C: Schedule of Benefits, including Copayments, Deductibles, Coinsurance and Penalties. The Plan may require proof that You have made any required Member Payment.

46. **Network Provider** - A Provider who has contracted with the Plan to provide access to benefits to Members at specified rates. Such Providers may be referred to as Blue Card PPO Participating Providers, Participating Hospitals, In-Transplant Network, etc.

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

48. **Open Enrollment Period** - Those periods of time agreed to by the Plan and the Group during which eligible Employees and their dependents may enroll as Members.

49. **Oral Appliance** – a device placed in the mouth and used to treat mild to moderate obstructive sleep apnea by repositioning or stabilizing the lower jaw, tongue, soft palate or uvula. An Oral Appliance may also be used to treat TMJ or TMD by stabilizing the jaw

joint. An Oral Appliance is not the same as an occlusal splint, which is used to treat malocclusion or misalignment of teeth.

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

51. O**ut-of-Pocket Maximum** - The total dollar amount, as stated in Attachment C: Schedule of Benefits, that a Member must incur and pay for Covered Services during the Annual Benefit Period, including Deductible and Coinsurance. There are 2 Out-of-Pocket Maximums – one for services rendered by Network Providers and one for services rendered by Out-of-Network Providers.

    Copayments, Penalties and any balance of charges (the difference between Billed Charges and the Maximum Allowable Charge) are not considered when determining if the Out-of-Pocket Maximum has been satisfied.

    When the In-Network Out-of-Pocket Maximum is satisfied, benefits are payable at 100% for other Covered Services from Network Providers incurred by the Member during the remainder of that Annual Benefit Period, excluding applicable Copayments and Penalties, and any balance of charges (the difference between Billed Charges and the Maximum Allowable Charge).

    When the Out-of-Network Out-of-Pocket Maximum is reached, benefits are payable at 100% for expenses for other Covered Services from Out-of-Network Providers incurred by the Member during the remainder of that Annual Benefit Period, excluding applicable Copayments and Penalties, and any balance of charges (the difference between Billed Charges and the Maximum Allowable Charge).

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

53. **Penalty/Penalties** – Additional Member Payments required as a result of failure to comply with Plan requirements such as failing to obtain Prior Authorization for certain Covered Services shown in Attachment C: Schedule of Benefits, as requiring such Prior Authorization. The Penalty will be a reduction in Plan payment for Covered Services.

54. **Periodic Health Screening** – An assessment of a patient's health status at intervals set forth in the Plan's Medical Policies, for the purpose of maintaining health and detecting disease in its early state. This assessment should include:

    a. a complete history or interval update of the patient's history and a review of systems; and

    b. a physical examination of all major organ systems, and screening tests per the Plan's Medical Policy.

55. **Practitioner** – A person licensed by the State to provide medical services.

56. **Pre-existing Condition** – Any physical or mental condition, regardless of cause, that was present during the six month period immediately before the earlier of when Your Coverage became effective under this EOC, or the first day of any Pre-Existing Condition Waiting Period, for which medical advice, diagnosis, care or treatment was recommended or received from a Provider of health care services.

    The following are not Pre-Existing Conditions:

    a. Genetic information in the absence of a diagnosis of the condition related to the genetic information; and

    b. Pregnancy.

    Anyone under the age of 19 is not considered to have a Pre-Existing Condition.

57. **Pre-existing Condition Waiting Period** – Up to a 12 month period that begins on the date Your Coverage became effective, or the first day of any eligibility waiting period, and during which benefits are not available for services received in connection with a Pre-existing Condition. If You are a Late Enrollee, this period can extend to 18 months. The Pre-Existing Condition Waiting Period is shown in Attachment C: Schedule of Benefits.

    The Pre-existing Condition Waiting Period will be reduced by the period of Creditable Coverage occurring within 18 months before the date Coverage becomes effective (provided there is no break of 63 days or more during which You were not Covered under any Creditable Coverage).

58. **Premium** – The total payment for Coverage under the Group Agreement, including amounts paid by You and the Group for such Coverage.

59. **Prior Authorization, Authorized** – A review conducted by the Plan, prior to the delivery of certain services, to determine if such services will be considered Covered Services.

60. **Provider** – A person or entity engaged in the delivery of health services who, or that is licensed, certified or practicing in accordance with applicable State or Federal laws.

61. **Qualified Medical Child Support Order** – A medical child support order, issued by a court of competent jurisdiction, that creates or recognizes the existence of a child's right to receive benefits for which a Subscriber is eligible under the Group Agreement. Such order shall identify the Subscriber and each such child by name and last known mailing address; give a description of the type and duration of coverage to be provided to each child; and identify each health plan to which such order applies.

62. **Rider** – An attachment or endorsement to this EOC providing additional or expanded benefits not otherwise Covered by the Plan.

63. **Specialty Drugs**– Injectable, infusion and select oral medications that require complex care, including special handling, patient education and continuous monitoring. Specialty Drugs are listed on the Plan's Specialty Drug list. Specialty Drugs are categorized as Provider-administered or self-administered.

64. **Subscriber** – An Employee who meets all applicable eligibility requirements, has enrolled for Coverage and for whom the Plan has received the applicable Premium for Coverage from the Group.

65. **Surgery or Surgical Procedure** - Medically Necessary and Appropriate surgeries or procedures. Surgeries involve an excision or incision of the body's skin or mucosal tissues, treatment of broken or dislocated bones, and/or insertion of instruments for exploratory or diagnostic purposes into a natural body opening.

66. **Totally Disabled or Total Disability** – Either: (a) You, if an Employee, are prevented from performing Your work duties and are unable to engage in any work or other gainful activity for which You are qualified or could reasonably become qualified to perform by reason of education, training, or experience because of injury or disease; or (b) You, if a Covered Dependent, are prevented from engaging in substantially all of the normal activities of a person of like age and sex in good health because of non-occupational injury or disease.

67. **Transplant Maximum Allowable Charge (TMAC) –** The amount that the Plan, in its sole discretion, has determined to be the maximum amount payable for Covered Services for Organ Transplants. Each type of Organ Transplant has a separate TMAC.

68. **Transplant Network** – A network of hospitals and facilities, each of which has agreed to perform specific organ transplants. For example, some hospitals might contract to perform heart transplants, but not liver transplants.

69. **Transplant Service -** Medically Necessary and Appropriate Services listed as Covered under the Transplant Service section in Attachment A of this EOC.

70. **Well Child Care –** A routine visit to a pediatrician or other qualified Practitioner to include Medically Necessary and Medically Appropriate Periodic Health Screenings, immunizations and injections for children through age 5.

71. **Well Woman Exam –** A routine visit every Annual Benefit Period to a Provider. The visit may include Medically Necessary and Medically Appropriate mammogram and cervical cancer screenings.

Evidence of Coverage

Attachment A:

Covered Services and Exclusions

Plan benefits are based on the Maximum Allowable Charge for Medically Necessary and Appropriate services and supplies described in this Attachment A and provided in accordance with the benefit schedules set forth in this EOC's Attachment C: Schedule of Benefits.

To be eligible for benefits, all services or supplies must be provided in accordance with the Plan's Medical Policies and procedures. (See the Prior Authorization, Care Management, Medical Policy and Patient Safety section for more information.)

This Attachment sets forth Covered Services and exclusions (services not Covered), and is arranged according to type of services.

Please also read Attachment B: Other Exclusions.

Your benefits are greater when You use Network Providers. The Plan contracts with Network Providers. Network Providers have agreed to accept the Maximum Allowable Charge as the basis for payment to the Provider for Covered Services. (See the Definitions section for an explanation of Maximum Allowable Charge and Covered Services.) Network Providers have also agreed not to bill You for amounts above the Maximum Allowable Charge.

Out-of-Network Providers do not have a contract with the Plan. This means they may be able to charge You more than the Maximum Allowable Charge (the amount set by the Plan in its contracts with Network Providers). When You use an Out-of-Network Provider for Covered Services, You will be responsible for any difference between what the Plan pays and what the Out-of-Network Provider charges. **This means that You may owe the Out-of-Network Provider a large amount of money.**

Obtaining services not listed as a Covered Service in this Attachment or not in accordance with the Plan's health Care Management policies and procedures may result in the denial of benefits or a reduction in reimbursement for otherwise eligible Covered Services.

Obtaining Prior Authorization is not a guarantee of Coverage. All provisions of the EOC must be satisfied before benefits for Covered Services will be provided. The Plan's medical policies can help Your Provider determine if a proposed service will be Covered.

When more than one treatment alternative exists, each is Medically Appropriate and Medically Necessary, and each would meet Your needs, We reserve the right to provide payment for the least expensive Covered Service alternative.

A. Practitioner Office Services

Medically Necessary and Appropriate services in a Practitioner's office.

1. Covered Services

   a. Diagnosis and treatment of illness or injury. (Note that allergy skin testing is Covered only in the practitioner office setting. Medically Necessary RAST (radioallergosorbent test), FAST (fluorescent allergosorbent test), or MAST (multiple radioallergosorbent test) allergy testing is Covered in the practitioner office setting and in a licensed laboratory.)

   b. Injections and medications administered in a Practitioner's office , except Specialty Drugs. (See Provider Administered Specialty Drugs section for information on Coverage).

   c. Second surgical opinions given by a Practitioner who is not in the same medical group as the Practitioner who initially recommended Surgery.

   d. Well Child Care for children through age 5, including appropriate immunizations, screenings and diagnostics. Once the Member reaches age 6, well care services are provided as described below.

   e. Preventive/Well Care Services.

      i. Preventive health exam for adults and children and related services as outlined below and performed by the physician during the preventive health exam or referred by the physician as appropriate, including:

         - Screenings and counseling services with an A or B recommendation by the United States Preventive Services Task Force (USPSTF)
         - Bright Futures recommendations for infants, children and adolescents supported by the Health Resources and Services Administration (HRSA)
         - Preventive care and screening for women as provided in the guidelines supported by HRSA, and
         - Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC).

         Generally, specific preventive services are covered for plan years beginning one year after the guidelines or recommendation went into effect. The frequency of visits and services are based on information from the agency responsible for the guideline or recommendation, or the application of medical management. These services include but are not limited to:

         - Annual Well Woman Exam, including cervical cancer screening, screening mammography at age 40 and older, and other USPSTF screenings with an A or B rating.
         - Colorectal cancer screening for members age 50-75.
         - Prostate cancer screening for men age 50 and older.
         - Screening and counseling in the primary care setting for alcohol misuse and tobacco use.
         - Dietary counseling for adults with hyperlipidemia, hypertension, Type 2 diabetes, obesity, coronary artery disease and congestive heart failure.
         - FDA-approved contraceptive methods, sterilization procedures and counseling for women with reproductive capacity. Note that prescription contraceptive products are covered under the Prescription Drug Rider.

- HPV testing once every 3 years for women age 30 and older.
- Lactation counseling by a trained provider during pregnancy or in the post-partum period, and manual breast pump.

Coverage may be limited as indicated in Attachment C: Schedule of Benefits.

2. Exclusions

   a. Office visits, physical exams and related immunizations and tests, when required solely for: (1) sports; (2) camp; (3) employment; (4) travel; (5) insurance; (6) marriage or legal proceedings.

   b. Routine foot care for the treatment of: (1) flat feet; (2) corns; (3) bunions; (4) calluses; (5) toenails; (6) fallen arches; and (7) weak feet or chronic foot strain.

   c. Rehabilitative therapies in excess of the limitations of the Therapeutic/Rehabilitative benefit.

   d. Dental procedures, except as otherwise indicated in this EOC.

B. Inpatient Hospital Services

Medically Necessary and Appropriate services and supplies in a Hospital that: (1) is a licensed Acute care institution; (2) provides Inpatient services; (3) has surgical and medical facilities primarily for the diagnosis and treatment of a disease and injury; and (4) has a staff of Physicians licensed to practice medicine and provides 24 hour nursing care by graduate registered nurses. Psychiatric hospitals are not required to have a surgical facility.

Prior Authorization for Covered Services must be obtained from the Plan, or benefits will be reduced or denied.

1. Covered Services

   a. Room and board in a semi-private room (or private room if room and board charges are the same as for a semi-private room); general nursing care; medications, injections, diagnostic services and special care units.

   b. Attending Practitioner's services for professional care.

   c. Maternity and delivery services (including routine nursery care and Complications of Pregnancy). If the hospital or physician provides services to the baby and submits a claim in the baby's name, benefits may be Covered for the baby and mother as separate Members, requiring payment of applicable Member Copayments and/or Deductibles.

2. Exclusions

   a. Inpatient stays primarily for therapy (such as physical or occupational therapy).

   b. Services that could be provided in a less intensive setting.

   c. Private room when not Authorized by the Plan and room and board charges are in excess of semi-private room.

   d. Blood or plasma that is provided at no charge to the patient.

C. Hospital Emergency Care Services

Medically Necessary and Appropriate health care services and supplies furnished in a Hospital emergency department that are required to determine, evaluate and/or treat an Emergency until such condition is stabilized, as directed or ordered by the Practitioner or Hospital protocol.

1. Covered Services

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

   b. Practitioner services.

2. Exclusions

   a. Treatment of a chronic, non-Emergency condition, where the symptoms have existed over a period of time, and a prudent layperson who possesses an average knowledge of health and medicine would not believe it to be an Emergency.

   b. Services received for inpatient care or transfer to another facility once Your medical condition has stabilized, unless Prior Authorization is obtained from the Plan within 24 hours or the next working day.

D. <u>Ambulance Services</u>

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

1. Covered Services

   a. Medically Necessary and Appropriate land or air transportation from the scene of an accident or Emergency to the nearest appropriate hospital.

2. Exclusions

   a. Transportation for Your convenience.

   b. Transportation that is not essential to reduce the probability of harm to You.

   c. Services when You are not transported to a hospital.

E. <u>Outpatient Facility Services</u>

Medically Necessary and Appropriate diagnostics, therapies and Surgery occurring in an outpatient facility that includes: (1) outpatient Surgery centers; (2) the outpatient center of a hospital; (3) outpatient diagnostic centers; and (4) certain surgical suites in a Practitioner's office. Prior Authorization as required for certain outpatient services must be obtained from the Plan, or benefits will be reduced or denied.

1. Covered Services

   a. Practitioner services.

   b. Outpatient diagnostics (such as x-rays and laboratory services).

   c. Outpatient treatments (such as medications and injections).

   d. Outpatient Surgery and supplies.

   e. Observation stays less than 24 hours.

2. Exclusions

   a. Rehabilitative therapies in excess of the terms of the Therapeutic/ Rehabilitative benefit.

   b. Services that could be provided in a less intensive setting.

F. Behavioral Health

Medically Necessary and Appropriate treatment of medical conditions resulting from behavioral health disorders.

1. Covered Services

   a. The treatment of medical conditions underlying, or resulting from, behavioral health disorders.

2. Exclusions

   a. Behavioral Health Services are not Covered, except as specified or Covered by the supplemental Rider (if applicable to Your Group Coverage).

G. Family Planning and Reproductive Services

Medically Necessary and Appropriate family planning services and those services to diagnose and treat diseases that may adversely affect fertility.

1. Covered Services

   a. Benefits for: (1) family planning; (2) history; (3) physical examination; (4) diagnostic testing; and (5) genetic testing.

   b. Sterilization procedures.

   c. Services or supplies for the evaluation of infertility.

   d. Medically Necessary and Appropriate termination of a pregnancy.

   e. Injectable and implantable hormonal contraceptives and vaginal barrier methods including initial fitting, insertion and removal.

2. Exclusions

   a. Services or supplies that are designed to create a pregnancy, enhance fertility or improve conception quality, including but not limited to: (1) artificial insemination; (2) in vitro fertilization; (3) fallopian tube reconstruction; (4) uterine reconstruction; (5) assisted reproductive technology (ART) including but not limited to GIFT and ZIFT; (6) fertility injections; (7) fertility drugs, (8) services for follow-up care related to infertility treatments.

   b. Services or supplies for the reversals of sterilizations.

   c. Induced abortion unless: (1) the health care Practitioner certifies in writing that the pregnancy would endanger the life of the mother, or; (2) the fetus is not viableor; (3) the pregnancy is a result of rape or incest, or; (4) the fetus has been diagnosed with a lethal or otherwise significant abnormality.

H. Reconstructive Surgery

Medically Necessary and Appropriate Surgical Procedures intended to restore normal form or function.

1. Covered Services

   a. Surgery to correct significant defects from congenital causes, (except where specifically excluded), accidents or disfigurement from a disease state.

   b. Reconstructive breast Surgery as a result of a mastectomy or partial mastectomy (other than lumpectomy) including Surgery on the non-diseased breast needed to establish symmetry between the two breasts.

2. Exclusions

   a. Services, supplies or prosthetics primarily to improve appearance.

   b. Surgeries to correct or repair the results of a prior Surgical Procedure, the primary purpose of which was to improve appearance, and surgeries to improve appearance following a prior Surgical Procedure, even if that prior procedure was a Covered Service.

   c. Surgeries and related services to change gender (transsexual Surgery).

I. Skilled Nursing/Rehabilitative Facility Services

Medically Necessary and Appropriate Inpatient care provided to Members requiring medical, rehabilitative or nursing care in a restorative setting. Services shall be considered separate and distinct from the levels of Acute care rendered in a hospital setting, or custodial or functional care rendered in a nursing home. Prior Authorization for Covered Services must be obtained from the Plan, or benefits will be reduced or denied.

1. Covered Services

   a. Room and board in a semi-private room, general nursing care, medications, diagnostics and special care units.

   b. The attending Practitioner's services for professional care.

   c. Coverage is limited as indicated in the Attachment C: Schedule of Benefits.

2. Exclusions

   a. Custodial, domiciliary or private duty nursing services.

   b. Skilled Nursing services not received in a Medicare certified skilled nursing facility.

   c. Services for cognitive rehabilitation.

J. Therapeutic/Rehabilitative Services

Medically Necessary and Appropriate therapeutic and rehabilitative services performed in a Practitioner's office, outpatient facility or home health setting and intended to restore or improve bodily function lost as the result of illness, injury, autism in children under age 12, or cleft palate.

1. Covered Services

   a. Outpatient, home health or office therapeutic and rehabilitative services that are expected to result in significant and measurable improvement in Your condition resulting from an Acute disease, injury, autism in children under age 12, or cleft palate. The services must be performed by, or under the direct supervision of a licensed therapist, upon written authorization of the treating Practitioner.

   b. Therapeutic/Rehabilitative Services include: (1) physical therapy; (2) speech therapy for restoration of speech; (3) occupational therapy; (4) manipulative therapy; and (5) cardiac and pulmonary rehabilitative services.

      (1) Speech therapy is Covered only for disorders of articulation and swallowing, resulting from Acute illness, injury, stroke, autism in children under age 12, or cleft palate.

   c. Coverage is limited, as indicated in Attachment C: Schedule of Benefits.

      (1) The limit on the number of visits for therapy applies to all visits for that therapy, whether received in a Practitioner's office, outpatient facility or home health setting.

(2) Services received during an inpatient hospital, skilled nursing or rehabilitative facility stay are Covered as shown in the inpatient hospital, skilled nursing and rehabilitative facility section, and are not subject to the therapy visit limits.

2. Exclusions

a. Treatment beyond what can reasonably be expected to significantly improve health, including therapeutic treatments for ongoing maintenance or palliative care.

b. Enhancement therapy that is designed to improve Your physical status beyond Your pre-injury or pre-illness state.

c. Complementary and alternative therapeutic services, including, but not limited to: (1) massage therapy; (2) acupuncture; (3) craniosacral therapy; (4) cognitive rehabilitation; (5) vision exercise therapy; and (6) neuromuscular reeducation. Neuromuscular reeducation refers to any form of athletic training, rehabilitation program or bodily movement that requires muscles and nerves to learn or relearn a certain behavior or specific sequence of movements. Neuromuscular reeducation is sometimes performed as part of a physical therapy visit.

d. Modalities that do not require the attendance or supervision of a licensed therapist. These include, but are not limited to: (1) activities that are primarily social or recreational in nature; (2) simple exercise programs; (3) hot and cold packs applied in the absence of associated therapy modalities; (4) repetitive exercises or tasks that You can perform without a therapist, in a home setting; (5) routine dressing changes; and (6) custodial services that can ordinarily be taught to You or a caregiver.

e. Behavioral therapy, play therapy, communication therapy, and therapy for self correcting language dysfunctions as part of speech therapy, physical therapy or occupational therapy programs. Behavioral therapy and play therapy for behavioral health diagnoses may be Covered under the Behavioral Health Rider (if applicable to Your Group Coverage).

f. Duplicate therapy. For example, when You receive both occupational and speech therapy, the therapies should provide different treatments and not duplicate the same treatment.

K. Organ Transplants

Organ Transplants - (As soon as Your Practitioner tells You that You might need a transplant, You or Your Practitioner must contact the Plan's Transplant Case Management department).

Medically Necessary and Appropriate services and supplies provided to You, when You are the recipient of the following organ transplant procedures: (1) heart; (2) heart/lung; (3) bone marrow; (4) lung; (5) liver; (6) pancreas; (7) pancreas/kidney; (8) kidney; (9) small bowel; and (10) small bowel/liver. Benefits may be available for other organ transplant procedures that, in Our sole discretion, are not experimental or Investigational and that are Medically Necessary and Medically Appropriate.

You have access to three levels of benefits: (1) In-Transplant Network, (2) In-Network, and (3) Out-of-Network. If You go to an In-Transplant Network Provider, You will have the highest level of benefits. (See section 3.f. for Kidney transplant benefit information).

Transplant services or supplies that have not received Prior Authorization will not be Covered. "Prior Authorization" is the pre-treatment authorization that must be obtained from Us before any pre-transplant evaluation or any Covered Procedure is performed. (See Prior Authorization Procedures below.)

1. Prior Authorization Procedures

To obtain Prior Authorization, You or Your Practitioner must contact the Plan's Transplant Case Management department before pre-transplant evaluation or Transplant Services are

received. Authorization should be obtained as soon as possible after You have been identified as a possible candidate for Transplant Services.

Transplant Case Management is a mandatory program for those Members seeking Transplant Services. Call the 800 number on Your membership ID card for customer service, and ask to be transferred to Transplant Case Management. We must be notified of the need for a transplant in order for the pre-transplant evaluation and the transplant to be Covered Services.

2. Covered Services

The following Medically Necessary and Appropriate Transplant Services and supplies that have received Prior Authorization and are provided in connection with a Covered Procedure:

a. Medically Necessary and Appropriate services and supplies, otherwise Covered under this EOC;

b. Medically Necessary and Appropriate services and supplies for each listed organ transplant are Covered only when Transplant Case Management approves a transplant. **Not all In-Network Providers are in Our Transplant Network. Please check with a Transplant case manager to see which Hospitals are in Our Transplant Network;**

c. Travel expenses for Your evaluation prior to a Covered Procedure, and to and from the site of a Covered Procedure by: (1) private car; (2) ground or air ambulance; or (3) public transportation. This includes travel expenses for You and a companion. A companion must be Your spouse, family member, Your guardian or other person approved by Transplant Case Management. In order to be reimbursed, travel must be approved by Transplant Case Management. In many cases, travel will not be approved for kidney transplants.

i. Travel by private car is limited to reimbursement at the IRS mileage rate in effect at the time of travel to and from a facility in the In-Transplant Network.

ii. Meals and lodging expenses, limited to $150 daily.

iii. The aggregate limit for travel expenses is $10,000 per Covered Procedure.

iv. Travel Expenses are Covered only if You go to an In-Transplant Network Institution;

d. Donor Organ Procurement. If the donor is not a Member, Covered Services for the donor are limited to those services and supplies directly related to the Transplant Service itself: (1) testing for the donor's compatibility; (2) removal of the organ from donor's body; (3) preservation of the organ; (4) transportation of the organ to the site of transplant; and (5) donor follow-up care. Services are Covered only to the extent not covered by other health coverage. The search process and securing the organ are also Covered under this benefit. Complications of donor organ procurement are not Covered. The cost of Donor Organ Procurement is included in the total cost of Your Organ Transplant.

3. Conditions/Limitations

The following limitations and/or conditions apply to services, supplies or Charges:

a. You or Your Practitioner must notify Transplant Case Management prior to Your receiving any Transplant Service, including pre-transplant evaluation, and obtain Prior Authorization. If Transplant Case Management is not notified, the transplant and related procedures will not be Covered at all;

b. Transplant Case Management will coordinate all transplant services, including pre-transplant evaluation. You must cooperate with Us in coordination of these services;

c. Failure to notify Us of proposed Transplant Services, or to coordinate all transplant related services with Us, will result in the reduction or exclusion of payment for those services;

d. You must go through Transplant Case Management and receive Prior Authorization for Your transplant to be Covered;

e. Once You have notified Transplant Case Management and received Prior Authorization, You may decide to have the transplant performed outside the Transplant Network. **However, Your benefits will be greatly limited, as described below. Only the Transplant Maximum Allowable Charge for the Service provided will be Covered;**

   i. In-Transplant Network transplants. You have the transplant performed at an In-Transplant Network Provider. You receive the highest level of reimbursement for Covered Services. The Plan will reimburse the In-Transplant Network Provider at the benefit level listed in Attachment C: Schedule of Benefits, at the Transplant Maximum Allowable Charge. The In-Transplant Network Provider can not bill You for any amount over the Transplant Maximum Allowable Charge for the transplant, which limits Your liability;

   ii. In-Network transplants. You have the transplant performed outside the Transplant Network, but still at a facility that is an In-Network Provider or a BlueCard PPO Participating Provider. The Plan will reimburse the In-Network or BlueCard PPO Participating Provider at the benefit level listed in Attachment C: Schedule of Benefits, limited to the Transplant Maximum Allowable Charge. There is no maximum to Your liability. The Provider also has the right to bill You for any amount not Covered by the Plan – this amount may be substantial;

   iii. Out-of-Network transplants. You have the transplant performed by an Out-of-Network Provider (i.e., outside the Transplant Network, and not at a facility that is an In-Network Provider or a BlueCard PPO Participating Provider). The Plan will reimburse the Out-of-Network Provider only at the benefit level listed in Attachment C: Schedule of Benefits, limited to the Transplant Maximum Allowable Charge. There is no maximum to Your liability. **The Out-of-Network Provider also has the right to bill You for any amount not Covered by the Plan - this amount may be substantial;**

   You can find out what the Transplant Maximum Allowable Charge is for Your transplant by contacting Transplant Case Management. Remember, the Transplant Maximum Allowable Charge can and does change from time to time.

f. Kidney transplants. There are two levels of benefits for kidney transplants: In-Network and Out-of-Network:

   i. In-Network kidney transplants. You have a kidney transplant performed at a facility that is an In-Network Provider or a BlueCard PPO Participating Provider. You receive the highest level of reimbursement for Covered Services. The In-Network or BlueCard PPO Participating Provider cannot bill You for any amount over the Maximum Allowable Charge for the transplant, which limits Your liability;

   ii. Out-of-Network kidney transplants. You have a kidney transplant performed by an Out-of-Network Provider (i.e. not at a facility that is an In-Network Provider or a BlueCard PPO Participating Provider). The Plan will reimburse the Out-of-Network Provider only at the benefit level listed in Attachment C: Schedule of Benefits, at the Maximum Allowable Charge. There is no maximum to Your liability. **The Out-of-Network Provider also has the right to bill You for any amount not Covered by the Plan; this amount may be substantial;**

g. If You go through Transplant Case Management for Your transplant, follow its procedures, cooperate fully with them, and have Your transplant performed at an In-Transplant Network Institution, the transplant expenses specified in Attachment C: Schedule of Benefits are Covered.

4. Exclusions

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

a. Transplant and related services that did not receive Prior Authorization;

b. Any service specifically excluded under Attachment B, Other Exclusions, except as otherwise provided in this section;

c. Services or supplies not specified as Covered Services under this section;

d. Any attempted Covered Procedure that was not performed, except where such failure is beyond Your control;

e. Non-Covered Services;

f. Services that would be covered by any private or public research fund, regardless of whether You applied for or received amounts from such fund;

g. Any non-human, artificial or mechanical organ;

h. Payment to an organ donor or the donor's family as compensation for an organ, or payment required to obtain written consent to donate an organ;

i. Donor services including screening and assessment procedures that have not received Prior Authorization from Us;

j. Removal of an organ from a Member for purposes of transplantation into another person, except as Covered by the Donor Organ Procurement provision as described above;

k. Harvest, procurement, and storage of stem cells, whether obtained from peripheral blood, cord blood, or bone marrow when reinfusion is not scheduled or anticipated to be scheduled within an appropriate time frame for the patient's covered stem cell transplant diagnosis.

l. Other non-organ transplants (e.g., cornea) are not Covered under this Section, but may be Covered as an Inpatient Hospital Service or Outpatient Facility Service, if Medically Necessary.

Note: If You receive Prior Authorization through Transplant Case Management, but do not obtain services through the Transplant Network, You will have to pay the Provider any additional charges not Covered by the Plan.

L. Dental Services

Medically Necessary and Appropriate services performed by a doctor of dental Surgery (DDS), a doctor of medical dentistry (DMD) or any Practitioner licensed to perform dental related oral Surgery except as indicated below.

1. Covered Services

a. Dental services and oral surgical care to treat intraoral cancer, or to treat accidental injury to the jaw, sound natural teeth, mouth, or face, due to external trauma. The Surgery and services to treat accidental injury must be started within 3 months and completed within 12 months of the accident.

b. For dental services not listed in subsection a. above, general anesthesia, nursing and related hospital expenses in connection with an inpatient or outpatient dental procedure are Covered, only when one of the 5 conditions listed below is met.

(1) Complex oral Surgical Procedures that have a high probability of complications due to the nature of the Surgery;

(2) Concomitant systemic disease for which the patient is under current medical management and that significantly increases the probability of complications;

(3) Mental illness or behavioral condition that precludes dental Surgery in the office;

(4) Use of general anesthesia and the Member's medical condition requires that such procedure be performed in a Hospital; or

(5) Dental treatment or Surgery performed on a Member 8 years of age or younger, where such procedure cannot be safely provided in a dental office setting.

Prior Authorization for inpatient services is required.

c. Extraction of impacted teeth, including wisdom teeth.

d. Oral Appliances to treat obstructive sleep apnea, if Medically Necessary.

2. Exclusions

a. Routine dental care and related services including, but not limited to: (1) crowns; (2) caps; (3) plates; (4) bridges; (5) dental x-rays; (6) fillings; (7) tooth extraction, except as listed above; (8) periodontal Surgery; (9) root canals; (10) preventive care (cleanings, x-rays); (11) replacement of teeth (including implants, false teeth, bridges); (12) bone grafts (alveolar Surgery); (13) treatment of injuries caused by biting and chewing; (14) treatment of teeth roots; and (15) treatment of gums surrounding the teeth.

b. Treatment for correction of underbite, overbite, and misalignment of the teeth including but not limited to, braces for dental indications, orthognathic surgery, and occlusal splints and occlusal appliances to treat malocclusion/misalignment of teeth.

M. Temporomandibular Joint Dysfunction (TMJ)

Medically Necessary and Appropriate services to diagnose and treat temporomandibular joint syndrome or dysfunction (TMJ or TMD).

1. Covered Services

a. Diagnosis and management of TMJ or TMD.

b. Surgical treatment of TMJ or TMD, if performed by a qualified oral surgeon or maxillofacial surgeon.

c. Non-surgical TMJ includes: (1) history and exam; (2) office visit; (3) x-rays; (4) diagnostic study casts; (5) medications; and (6) Oral Appliances to stabilize jaw joint.

2. Exclusions

a. Treatment for routine dental care and related services including, but not limited to: (1) crowns; (2) caps; (3) plates; (4) bridges; (5) dental x-rays; (6) fillings; (7) periodontal surgery; (8) tooth extraction; (9) root canals; (10) preventive care (cleanings, x-rays); (11) replacement of teeth (including implants, false teeth, bridges); (12) bone grafts (alveolar surgery); (13) treatment of injuries caused by biting and chewing; (14) treatment of teeth roots; and (15) treatment of gums surrounding the teeth.

b. Treatment for correction of underbite, overbite, and misalignment of the teeth including braces for dental indications.

N. Diagnostic Services

Medically Necessary and Appropriate diagnostic radiology services and laboratory tests. Prior Authorization for Advanced Radiological Imaging must be obtained from the Plan, or benefits will be reduced or denied.

1. Covered Services

a. Imaging services ordered by a Practitioner, including x-ray, ultrasound, bone density test, and Advanced Radiological Imaging Services. Advanced Radiological Imaging Services include MRIs, CT scans, PET scans, nuclear cardiac imaging.

b. Diagnostic laboratory services ordered by a Practitioner.

2. Exclusions

a. Diagnostic services that are not Medically Necessary and Appropriate.

b. Diagnostic services not ordered by a Practitioner.

O. Drugs

Medically Necessary and Appropriate pharmaceuticals for the treatment of disease or injury.

1. Covered Services

a. Benefits for the treatment of phenylketonuria (PKU), including special dietary formulas while under the supervision of a Practitioner. If prescription drugs are covered under a supplemental Rider, dietary formulas to treat PKU will be Covered under that Rider.

b. Pharmaceuticals that are dispensed or intended for use while You are confined in a hospital, skilled nursing facility or other similar facility.

2. Exclusions

a. Except as specified or Covered by supplemental Rider, this Plan does not provide coverage for prescription drugs except as indicated above.

b. Those pharmaceuticals that may be purchased without a prescription.

P. Provider Administered Specialty Drugs

Medically Necessary and Appropriate Specialty Drugs for the treatment of disease, administered by a Practitioner or home health care agency and listed as a Provider-administered drug on the Plan's Specialty Drug list. Certain Specialty Drugs require Prior Authorization from the Plan, or benefits will be reduced or denied. Call customer service at the number listed on Your membership ID card or check Our web site (www.bcbst.com) to find out which Specialty Drugs require Prior Authorization.

1. Covered Services

a. Provider-administered Specialty Drugs, including administration by a qualified Provider. Check Our web site (www.bcbst.com) to view the Specialty Drug list or call customer service with questions about a specific drug's classification. Only those drugs listed as Provider-administered Specialty Drugs are Covered under this benefit.

2. Exclusions

a. Self-administered Specialty Drugs as identified on the Plan's Specialty Drug list, except as may be Covered by a supplemental Rider.

b. FDA-approved drugs used for purposes other than those approved by the FDA, unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia.

Q. Vision

Medically Necessary and Appropriate diagnosis and treatment of diseases and injuries that impair vision.

1. Covered Services

   a. Services and supplies for the diagnosis and treatment of diseases and injuries to the eye.

   b. The first set of eyeglasses or contact lens required to adjust for vision changes due to cataract Surgery and obtained within 6 months following the Surgery.

2. Exclusions

   a. Routine vision services, including services, surgeries and supplies to detect or correct refractive errors of the eyes.

   b. Eyeglasses, contact lenses and examinations for the fitting of eyeglasses and contact lenses.

   c. Eye exercises and/or therapy.

   d. Visual training.

R. <u>Durable Medical Equipment</u>

Medically Necessary and Appropriate medical equipment or items that: (1) in the absence of illness or injury, are of no medical or other value to You; (2) can withstand repeated use in an ambulatory or home setting;(3) require the prescription of a Practitioner for purchase; (4) are approved by the FDA for the illness or injury for which it is prescribed; and (5) are not solely for Your convenience.

1. Covered Services

   a. Rental of Durable Medical Equipment - Maximum allowable rental charge not to exceed the total Maximum Allowable Charge for purchase. If You rent the same type of equipment from multiple DME Providers, and the total rental charges from the multiple Providers exceed the purchase price of a single piece of equipment, You will be responsible for amounts in excess of the Maximum Allowable Charge for purchase.

   b. The repair, adjustment or replacement of components and accessories necessary for the effective functioning of Covered equipment.

   c. Supplies and accessories necessary for the effective functioning of Covered Durable Medical Equipment.

   d. The replacement of items needed as the result of normal wear and tear, defects or obsolescence and aging. Insulin pump replacement is Covered only for pumps older than 48 months and only if the pump cannot be repaired.

2. Exclusions

   a. Charges exceeding the total cost of the Maximum Allowable Charge to purchase the equipment.

   b. Unnecessary repair, adjustment or replacement or duplicates of any such equipment.

   c. Supplies and accessories that are not necessary for the effective functioning of the Covered equipment.

   d. Items to replace those that were lost, damaged, stolen or prescribed as a result of new technology.

   e. Items that require or are dependent on alteration of home, workplace or transportation vehicle.

   f. Motorized scooters, exercise equipment, hot tubs, pool, saunas.

g. "Deluxe" or "enhanced" equipment. The most basic equipment that will provide the needed medical care will determine the benefit.

h. Computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, and seat lifts of any kind.

i. Patient lifts, auto tilt chairs, air fluidized beds, or air flotation beds, unless approved by Case Management for a Member who is in Case Management.

j. Portable ramp for a wheelchair.

S. Diabetes Treatment

Medically Necessary and Appropriate diagnosis and treatment of diabetes. In order to be Covered, such services must be prescribed and certified by a Practitioner as Medically Necessary. The treatment of diabetes consists of medical equipment, supplies, and outpatient self-management training and education, including nutritional counseling. If prescription drugs are Covered under a supplemental Rider, items a. through j. will be Covered under that Rider.

1. Covered Services

   a. Blood glucose monitors, including monitors designed for the legally blind.

   b. Test strips for blood glucose monitors.

   c. Visual reading and urine test strips.

   d. Insulin.

   e. Injection aids.

   f. Syringes.

   g. Lancets.

   h. Oral hypoglycemic agents.

   i. Glucagon emergency kits.

   j. Injectible incretin mimetics (e.g., Exenatide/Byetta) when used in conjunction with selected Prescription Drugs for the treatment of diabetes.

   k. Insulin pumps, infusion devices, and appurtenances. Insulin pump replacement is Covered only for pumps older than 48 months and if the pump cannot be repaired.

   l. Podiatric appliances for prevention of complications associated with diabetes.

2. Exclusions

   a. Treatments or supplies that are not prescribed and certified by a Practitioner as being Medically Necessary.

   b. Supplies not required by state statute.

T. Prosthetics/Orthotics

Medically Necessary and Appropriate devices used to correct or replace all or part of a body organ or limb that may be malfunctioning or missing due to: (1) birth defect; (2) accident; (3) illness; or (4) Surgery.

1. Covered Services

a. The initial purchase of surgically implanted prosthetic or orthotic devices.

b. The repair, adjustment or replacement of components and accessories necessary for the effective functioning of Covered equipment.

c. Splints and braces that are custom made or molded, and are incidental to a Practitioner's services or on a Practitioner's order.

d. The replacement of Covered items required as a result of normal wear and tear, defects or obsolescence and aging.

e. The initial purchase of artificial limbs or eyes,

f. The first set of eyeglasses or contact lens required to adjust for vision changes due to cataract surgery and obtained within 6 months following the Surgery. Benefits for eyeglasses or contact lens are limited as indicated in Attachment C: Schedule of Benefits.

g. Hearing aids, limited as indicated in Attachment C: Schedule of Benefits.

2. Exclusions

a. Prosthetics primarily for cosmetic purposes, including but not limited to wigs, or other hair prosthesis or transplants.

b. Items to replace those that were lost, damaged, stolen or prescribed as a result of new technology.

c. The replacements of contacts after the initial pair have been provided following cataract Surgery.

d. Foot orthotics, shoe inserts and custom made shoes except as required by law for diabetic patients or as a part of a leg brace.

U. <u>Home Health Care Services</u>

Medically Necessary and Appropriate services and supplies provided in Your home by a Practitioner who is primarily engaged in providing home health care services. Home visits by a skilled nurse require Prior Authorization. Therapy performed in the home does not require Prior Authorization.

1. Covered Services

a. Part-time, intermittent health services, supplies, and medications, by or under the supervision of a registered nurse.

b. Home infusion therapy.

c. Rehabilitative therapies such as physical therapy, occupational therapy, etc. (subject to the limitations of the Therapeutic/Rehabilitative benefit.)

d. Medical social services.

e. Dietary guidance.

f. Coverage is limited as indicated in Attachment C: Schedule of Benefits.

2. Exclusions

a. Items such as non-treatment services or: (1) routine transportation; (2) homemaker or housekeeping services; (3) behavioral counseling; (4) supportive environmental equipment; (5) Maintenance Care or Custodial Care; (6) social casework; (7) meal delivery; (8) personal hygiene; and (9) convenience items.

V. Hospice

Medically Necessary and Appropriate services and supplies for supportive care where life expectancy is 6 months or less.

1. Covered Services

   a. Benefits will be provided for: (1) part-time intermittent nursing care; (2) medical social services; (3) bereavement counseling; (4) medications for the control or palliation of the illness; (5) home health aide services; and (6) physical or respiratory therapy for symptom control.

2. Exclusions

   a. Inpatient hospice services, unless approved by Case Management.

   b. Services such as: (1) homemaker or housekeeping services; (2) meals; (3) convenience or comfort items not related to the illness; (4) supportive environmental equipment; (5) private duty nursing; (6) routine transportation; and (7) funeral or financial counseling.

W. Supplies

Those Medically Necessary and Appropriate expendable and disposable supplies for the treatment of disease or injury.

1. Covered Services

   a. Supplies for the treatment of disease or injury used in a Practitioner's office, outpatient facility or inpatient facility.

   b. Supplies for treatment of disease or injury that are prescribed by a Practitioner and cannot be obtained without a Practitioner's prescription.

2. Exclusions

   a. Supplies that can be obtained without a prescription (except for diabetic supplies). Examples include but are not limited to: (1) adhesive bandages; (2) dressing material for home use; (3) antiseptics, (4) medicated creams and ointments; (5) cotton swabs; and (6) eyewash.

EVIDENCE OF COVERAGE

ATTACHMENT B: OTHER EXCLUSIONS

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

1. Services or supplies not listed as Covered Services under Attachment A, Covered Service;
2. Services or supplies that are determined to be not Medically Necessary and Appropriate;
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. Illness or injury resulting from war, that occurred before Your Coverage began under this EOC and that is Covered by: (1) veteran's benefit; or (2) other coverage for which You are legally entitled;
5. Self treatment or training;
6. Staff consultations required by hospital or other facility rules;
7. Services that are free;
8. 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 of an Employee who is (1) a sole-proprietor of the Group, unless required by law to carry worker's compensation insurance; (2) a partner of the Group, unless required by law to carry worker's compensation insurance; or (3) a corporate officer of the Group, provided the officer filed an election not to accept Workers' Compensation with the appropriate government department;
9. Personal, physical fitness, recreational or convenience items and services, even if ordered by a licensed practitioner, including but not limited to: weight loss programs and equipment; physical fitness/exercise programs and equipment; devices and computers to assist in communication or speech (e.g., Dynabox); air conditioners, humidifiers, air filters and heaters; saunas, swimming pools and whirlpools; water purifiers; tanning beds; televisions; barber and beauty services.
10. Services or supplies received before Your effective date for Coverage with this Plan;
11. Services or supplies related to a Hospital Confinement, received before Your effective date for Coverage with this Plan;
12. Services or supplies received after Your Coverage under this Plan ceases for any reason. This is true even though the expenses relate to a condition that began while You were Covered. The only exception to this is described under the Extended Benefits section.
13. Services or supplies received in a dental or medical department maintained by or on behalf of the employer, mutual benefit association, labor union or similar group;
14. Services or charges to complete a claim form or to provide medical records or other administrative functions. We will not charge You or Your legal representative for statutorily required copying charges;
15. Charges for failure to keep a scheduled appointment;
16. Charges for telephone consultations, e-mail or web based consultations, except as may be provided for by specially arranged Care Management programs or emerging health care programs as described in the Prior Authorization, Care Management, Medical Policy and Patient Safety section of this EOC;
17. Court ordered examinations and treatment, unless Medically Necessary;
18. Room, board and general nursing care rendered on the date of discharge, unless admission and discharge occur on the same day;

19. Benefits for Pre-existing Conditions are excluded until any Pre-existing Condition Waiting Periods have been met. Refer to Pre-existing Condition Waiting Period in Attachment C: Schedule of Benefits;
20. Charges in excess of the Maximum Allowable Charge for Covered Services;
21. Any service stated in the Attachment A as a non-Covered Service or limitation;
22. Charges for services performed by You or Your spouse, or Your or Your spouse's parent, sister, brother or child;
23. Any charges for handling fees;
24. Nicotine replacement therapy and aids to smoking cessation including, but not limited to, patches;
25. Safety items, or items to affect performance primarily in sports-related activities;
26. 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;
27. 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 has been determined to be Medically Necessary, including leaving an inpatient medical facility against the advice of the treating physician;
28. Cosmetic services, except as appropriate per medical policy. 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, (12) piercing ears or other body parts, (13) rhytidectomy or rhytidoplasty (Surgery for the removal or elimination of wrinkles), (14) rhinoplasty, (15) panniculectomy/abdominoplasty, (17) thighplasty, (18) brachioplasty;
29. Blepharoplasty and browplasty;
30. Charges relating to surrogate pregnancy, including but not limited to maternity and delivery charges, whether or not the surrogate mother is Covered under this plan;
31. Sperm preservation;
32. Services or supplies for orthognathic Surgery, a discipline to specifically treat malocclusion. Orthognathic surgery is not surgery to treat cleft palate.
33. Services or supplies for Maintenance Care;
34. Private duty nursing;
35. Services or supplies to treat sexual dysfunction, regardless of cause, including but not limited to erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido;
36. Services or supplies related to complications of cosmetic procedures;
37. Services or supplies related to complications of bariatric Surgery; re-operation of bariatric Surgery or body remodeling after weight loss;
38. Cranial orthosis, including helmet or headband, for the treatment of non-synostotic plagiocephaly;
39. 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;

40. Vagus nerve stimulation for the treatment of depression;
41. Balloon sinuplasty for treatment of chronic sinusitis;
42. Treatment for benign gynecomastia;
43. Treatment for hyperhidrosis;
44. Intradiscal annuloplasty to treat discogenic back pain. This procedure provides controlled delivery of heat to the intervertebral disc through an electrode or coil.

ATTACHMENT C: SCHEDULE OF BENEFITS

HRA-Compatible Plan

Group Name: City of Gallatin
Group Number: 109340
Effective Date: October 1, 2012

PLEASE READ THIS IMPORTANT STATEMENT: In-Network benefits apply to services received from Network Providers and Non-Contracted Providers. **Out-of-Network benefit percentages apply to BCBST Maximum Allowable Charge, not to the Provider's billed charge. When using Out-of-Network Providers, the Member must pay the difference between the Provider's price and the Maximum Allowable Charge. This amount can be substantial.** For more information, please refer to the definitions of Coinsurance and Maximum Allowable Charge in the Definitions section of this EOC.

Covered Services	In-Network Benefits for Covered Services received from Network Providers	Out-of-Network Benefits for Covered Services received from Out-of-Network Providers
Service Received at the Practitioner's office		
Office Exams and Consultations		
Diagnosis and treatment of illness or injury Primary Care Practitioner types (Internal Medicine, General Practice, Family Practice, Pediatrics, Obstetrics & Gynecology, Physician Assistants, Nurse Practitioners) All other Practitioners	100% after $20 Copayment 100% after $40 Copayment	60% of the Maximum Allowable Charge after Deductible
Maternity care The Copayment applies to the initial office visit to confirm pregnancy. For benefits for subsequent prenatal visits, postnatal visits and the physician delivery charge, see **Inpatient Hospital Stays, including maternity stays** in the section **Services Received at a Facility**. Benefits for specialty care, even if related to pregnancy, are considered as any other illness, and a separate Copayment will apply. **Note that many OB/Gyns file a single claim for prenatal visits and maternity/delivery services provided in the hospital by the OB/Gyn. However, some file a claim for each visit. Member cost share is applied based on how the practitioner files claims.**	100% after $20 Copayment	60% of the Maximum Allowable Charge after Deductible

Preventive/Well Care Services Includes preventive health exam, screenings and counseling services. Alcohol misuse and tobacco use counseling limited to 8 visits annually; must be provided in the primary care setting; Dietary counseling for adults with hyperlipidemia, hypertension, Type 2 diabetes, coronary artery disease and congestive heart failure limited to 6 visits annually.	100%	60% of the Maximum Allowable Charge after Deductible
Well Woman Exam	100%	60% of the Maximum Allowable Charge after Deductible
Injections and Immunizations		
Allergy injections and allergy extract	100%	60% of the Maximum Allowable Charge after Deductible
Immunizations	100%	60% of the Maximum Allowable Charge after Deductible
Provider-Administered Specialty Drugs	100% after $100 Copayment	60% of the Maximum Allowable Charge after Deductible
All other medicine injections, excluding Specialty Drugs For surgery injections, please see Office Surgery under the Other office procedures, services or supplies section.	100%	60% of the Maximum Allowable Charge after Deductible
Diagnostic Services and Screenings (e.g. x-ray and labwork)		
Allergy Testing	100%	60% of the Maximum Allowable Charge after Deductible
Advanced Radiological Imaging Includes CAT scans, CT scans, MRIs, PET scans, nuclear medicine and other similar technologies. **Advanced Radiological Imaging services require Prior Authorization**. If Prior Authorization is not obtained, and services are Medically Necessary, benefits may be reduced to 50% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). If the reduction to 50% results in liability to the Member greater than $2,500 above what the Member would have paid had Prior Authorization been obtained, then the Member may contact customer service to have the claim reviewed and adjusted and the reduction will be limited to $2,500. (Services that are determined to not be Medically Necessary are not Covered.) 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.	80% after Deductible	60% of the Maximum Allowable Charge after Deductible

All Other Diagnostic Services for illness or injury	100%	60% of the Maximum Allowable Charge after Deductible
Maternity care diagnostic services	100%	60% of the Maximum Allowable Charge after Deductible
Screening mammogram, Cervical Cancer screening and Prostate cancer screening	100%	60% of the Maximum Allowable Charge after Deductible
Other Well Care Screenings, including screening colonoscopy and screening sigmoidoscopy.	100%	60% of the Maximum Allowable Charge after Deductible
Other office procedures, services, or supplies		
Office Surgery, including anesthesia, performed in and billed by the Practitioner's office		
Primary Care Practitioner types (Internal Medicine, General Practice, Family Practice, Pediatrics, Obstetrics & Gynecology, Physician Assistants, Nurse Practitioners)	100% after $20 Copayment	60% of the Maximum Allowable Charge after Deductible
All other Practitioners	100% after $40 Copayment	
Some procedures require Prior Authorization. Call customer service to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, and services are Medically Necessary, benefits may be reduced to 50% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). If the reduction to 50% results in liability to the Member greater than$2,500 above what the Member would have paid had Prior Authorization been obtained, then the Member may contact customer service to have the claim reviewed and adjusted and the reduction will be limited to $2,500. (Services that are determined to not be Medically Necessary are not Covered.) 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 incisions, excisions, biopsies, injection treatments, fracture treatments, applications of casts and splints, sutures, and invasive diagnostic services (e.g., colonoscopy, sigmoidoscopy and endoscopy).		

Therapy Services: Physical, speech, occupational, and manipulative therapy limited to 30 visits per therapy type per Annual Benefit Period; Cardiac and pulmonary rehab therapy limited to 36 visits per therapy type per Annual Benefit Period An office visit Copayment may apply to Evaluation and Management claims filed by a therapy provider. Please refer to Office Exams and Consultations, Diagnosis and treatment of illness or injury at the beginning of this Schedule	100% after $40 Copayment	60% of the Maximum Allowable Charge after Deductible
Non-routine treatments: Includes renal dialysis, radiation therapy, chemotherapy and infusions. Does not apply to Specialty Drugs. See Provider Administered Specialty Drugs section for applicable benefit.	100% after $40 Copayment	60% of the Maximum Allowable Charge after Deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Supplies	100%	60% of the Maximum Allowable Charge after Deductible
All Other Office services	100%	60% of the Maximum Allowable Charge after Deductible

Services Received at a Facility

Inpatient Hospital Stays, including maternity stays:

Prior Authorization required. Benefits will be reduced to 50% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers) when Prior Authorization is not obtained and services are Medically Necessary. If the reduction to 50% results in liability to the Member greater than $2,500 above what the Member would have paid had Prior Authorization been obtained, then the Member may contact customer service to have the claim reviewed and adjusted and the reduction will be limited to $2,500. (Services that are determined to not be Medically Necessary are not Covered.) 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	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Practitioner charges (including global maternity delivery charges billed as inpatient service)	80% after Deductible	60% of the Maximum Allowable Charge after Deductible

Skilled Nursing or Rehabilitation Facility stays: (Limited to 60 days combined per Annual Benefit Period) Prior Authorization required. Benefits will be reduced to 50% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers) when Prior Authorization is not obtained and services are Medically Necessary. If the reduction to 50% results in liability to the Member greater than $2,500 above what the Member would have paid had Prior Authorization been obtained, then the Member may contact customer service to have the claim reviewed and adjusted and the reduction will be limited to $2,500. (Services that are determined to not be Medically Necessary are not Covered.) 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	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Practitioner charges	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Hospital Emergency Care services		
Emergency Room Charges Note that an observation stay that occurs in conjunction with an ER visit will be subject to member cost share under the Outpatient Facility Services section, below, in addition to member cost share for the ER visit.	100% after $250 Copayment	100% after $250 Copayment
Advanced Radiological Imaging Services Includes CAT scans, CT scans, MRIs, PET scans, nuclear medicine and other similar technologies.	80% after Deductible	80% after Deductible
All Other Hospital Charges	100%	100%
Practitioner charges	100%	100%
Outpatient Facility Services **Outpatient Surgery** Some procedures require Prior Authorization. Call customer service to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, and services are Medically Necessary, benefits may be reduced to 50% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). If the reduction to 50% results in liability to the Member greater than $2,500 above what the Member would have paid had Prior Authorization been obtained, then the Member may contact customer service to have the claim reviewed and adjusted and the reduction will be limited to $2,500. (Services that are determined to not be Medically Necessary are not Covered.) 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	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Practitioner charges	80% after Deductible	60% of the Maximum Allowable Charge after Deductible

Outpatient Diagnostic Services and Outpatient Screenings		
Advanced Radiological Imaging Includes CAT scans, MRI's, PET scans, nuclear medicine and other similar technologies. **Advanced Radiological Imaging services require Prior Authorization**. If Prior Authorization is not obtained, and services are Medically Necessary, benefits may be reduced to 50% for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). If the reduction to 50% results in liability to the Member greater than $2,500 above what the Member would have paid had Prior Authorization been obtained, then the Member may contact customer service to have the claim reviewed and adjusted and the reduction will be limited to $2,500. (Services that are determined to not be Medically Necessary are not Covered.) 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.	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
All other diagnostic services for illness or injury	100%	60% of the Maximum Allowable Charge after Deductible
Maternity care diagnostic services	100%	60% of the Maximum Allowable Charge after Deductible

Screening Mammogram, Cervical cancer screening and Prostate cancer screening	100%	60% of the Maximum Allowable Charge after Deductible
Other Well Care Screenings, including screening colonoscopy and screening sigmoidoscopy.	100%	60% of the Maximum Allowable Charge after Deductible
Other Outpatient procedures, services, or supplies		
Therapy Services: Physical, speech, occupational, and manipulative therapy limited to 30 visits per therapy type per Annual Benefit Period; Cardiac and pulmonary rehab therapy limited to 36 visits per therapy type per Annual Benefit Period	100% after $40 Copayment	60% of the Maximum Allowable Charge after Deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Supplies	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Provider Administered Specialty Drugs	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
All Other services received at an outpatient facility, including chemotherapy, radiation therapy, renal dialysis and sleep studies	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Other Services		
Ambulance	80% after Deductible	80% after Deductible
Home Health Care Services, including home infusion therapy Prior Authorization is required for skilled nurse visits in the home, including those for home infusion therapy. Physical, speech or occupational therapy provided in the home does not require Prior Authorization. Home Health Care is limited to 60 visits per Annual Benefit Period	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Hospice Care	100%	60% of the Maximum Allowable Charge after Deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after Deductible	60% of the Maximum Allowable Charge after Deductible

Supplies	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Hearing Aids Limited to per ear every 2 years (as determined by Your Annual Benefit Period)	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Lactation counseling by a trained provider during pregnancy or in the post-partum period. Limited to one visit per pregnancy.	100%	60% of the Maximum Allowable Charge after Deductible
Manual Breast Pump, limited to one per pregnancy	100%	60% of the Maximum Allowable Charge after Deductible
FDA-approved contraceptive methods, sterilization procedures and counseling for women with reproductive capacity.	100%	60% of the Maximum Allowable Charge 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.	**In-Transplant Network benefits:** 80% 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):** 80% 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:** 60% 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.
Organ Transplant Services, kidney transplants All Organ Transplants require Prior Authorization. Benefits will be denied without Prior Authorization. Call us at the number on Your ID Card before any pre-transplant evaluation or other transplant service is performed to begin the Authorization process	**Network Providers:** 80% after Network Deductible; Network Out-of-Pocket Maximum applies.		**Out-of-Network Providers:** 60% 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.

	In-Network Services received from Network Providers	Out-of-Network Services received from Out-of-Network Providers
Deductible		
Individual	$1,500	$3,000
Family	$1,500 per Member, not to exceed $3,000 for all Covered Family Members	$3,000 per Member, not to exceed $6,000 for all Covered Family Members
Out-of-Pocket Maximum		
Individual	$2,500	$7,500
Family	$2,500 per Member, not to exceed $5,000 for all Covered Family Members.	$7,500 per Member, not to exceed $15,000 for all Covered Family Members.
Pre-Existing Condition Waiting Period	12 Months (1)	
4th Quarter Deductible Carryover (2)	Excluded	
Annual Benefit Period	January 1 - December 31	

1. HIPAA regulations apply. A Member's pre-existing condition waiting period can be reduced by the Member's applicable "creditable coverage".
2. Dollar amounts incurred during the last three (3) months of a Calendar Year that are applied to the Deductible during that Calendar Year will not apply to the Deductible for the next Calendar Year.

When services that require Prior Authorization are received from Out-of-Network Providers, and Network Providers outside Tennessee, You are responsible for obtaining Prior Authorization. Benefits may be reduced to 50% for Out-of-Network Providers and Network Providers outside Tennessee when Prior Authorization is not obtained.

PHARMACY PRESCRIPTION DRUG PROGRAM RIDER

BLUECROSS BLUESHIELD OF TENNESSEE, INC.
1 CAMERON HILL CIRCLE
CHATTANOOGA, TENNESSEE 37402

Notwithstanding any Group Agreement provision, amendment, or endorsement to the contrary, the EOC is amended to include the attached Pharmacy Prescription Drug Program Rider.

This Rider may use terms that are different from the terms in Your EOC. Please read the "Definitions" section of this Rider carefully to understand how Your benefits work.

I. BENEFITS FOR PRESCRIPTION CONTRACEPTIVE DRUGS

This plan covers the following at 100%, in accordance with the Women's Preventive Services provision of the Affordable Care Act.

- Generic contraceptives
- Vaginal ring
- Hormonal patch
- Emergency contraception available with a prescription

Brand name Prescription Contraceptive Drugs are covered as indicated in section II below.

II. BENEFITS FOR PRESCRIPTION DRUGS

Generic Drugs: $10 Drug Copayment per Prescription

Preferred Brand Drugs: $25 Drug Copayment per Prescription

Non-Preferred Brand Drugs: $50 Drug Copayment per Prescription

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

Your copayments vary based on the days supply dispensed, as shown below:

	One month supply (Up to 30 days)	Two months supply (31 to 60 days)	Three months supply (61 to 90 days)
	Generic Drug / Preferred Brand Drug / Non-Preferred Brand Drug	Generic Drug / Preferred Brand Drug / Non-Preferred Brand Drug	Generic Drug / Preferred Brand Drug / Non-Preferred Brand Drug
Retail Network	$10/$25/$50	N/A	N/A
Home Delivery Network and Home Delivery Retail Network	$10/$25/$50	$20/$50/$100	$20/$50/$100
Out-of-Network	You pay all costs, then file a claim for reimbursement.		

Some products may be subject to additional Quantity and Step Therapy Limitations as adopted by Us.

No Drug Copayment in this Rider apply to satisfying any Deductible, Coinsurance, Benefit Maximum amounts or Out-of-Pocket Maximums in the Plan.

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

If You have a Prescription filled at an Out-of-Network Pharmacy, You must pay all expenses and file a claim for reimbursement with Us. You will be reimbursed based on the Maximum Allowable Charge, less any applicable Drug Deductible, Coinsurance, and/or Drug Copayment amount.

I. BENEFITS FOR SELF-ADMINISTERED SPECIALTY DRUGS

You have a distinct network for Specialty Drugs: the specialty pharmacy network. You receive the highest level of benefits when You use a specialty pharmacy network provider for Your self-administered Specialty Drugs. (Please refer to Your EOC for information on benefits for provider-administered Specialty Drugs.)

When purchasing self-administered Specialty Drugs from an Out-of-Network Pharmacy, You must pay all expenses and file a claim for reimbursement with Us. You will be reimbursed based on the Maximum Allowable Charge, less any applicable Deductible, Coinsurance, and/or Drug Copayment amount.

Specialty Drugs are limited to a 30 day supply per Prescription.

	Specialty Pharmacy Network	Other Network Pharmacies	Out-of-Network
Self-administered Specialty Drugs, as indicated on Our Specialty Drug list.	$100 Drug Copayment per Prescription	$200 Drug Copayment per Prescription	You pay all costs, then file a claim for reimbursement.
If a drug that is on Our Specialty Drug 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 Drug as indicated on Our Specialty Drug list.	$20 Drug Copayment per Prescription	$40 Drug Copayment per Prescription	You pay all costs, then file a claim for reimbursement.
A Preferred Brand Drug that is also a Self-Administered Specialty Drug, as indicated on Our Specialty Drug list.	$50 Drug Copayment per Prescription	$100 Drug Copayment per Prescription	You pay all costs, then file a claim for reimbursement.

II. COVERED SERVICES

- Prescription Drugs prescribed when You are not confined in a hospital or other facility. Prescription Drugs must be:
  - prescribed on or after Your Coverage begins;
  - approved for use by the Food and Drug Administration (FDA);
  - dispensed by a licensed pharmacist
  - listed on the Drug Formulary; and
  - not available for purchase without a Prescription.
- Treatment of phenylketonuria (PKU), including special dietary formulas while under the supervision of a Practitioner.
- Injectable insulin, and insulin needles/syringes, lancets, alcohol swabs and test strips for glucose monitoring upon Prescription.
- Medically Necessary Prescription Drugs used during the induction or stabilization/dose-reduction phases of chemical dependency treatment.

III. LIMITATIONS

- Refills must be dispensed pursuant to a Prescription. If the number of refills is not specified in the Prescription, benefits for refills will not be provided beyond one year from the date of the original Prescription.
- The Plan has time limits on how soon a Prescription can be refilled. If You request a refill too soon, the Network Pharmacy will advise You when Your Prescription benefit will Cover the refill.
- Certain drugs are not Covered except when prescribed under specific circumstances as determined by the P & T Committee, including but not limited to:

- Drugs for the treatment of onychomycosis (e.g., nail fungus) are not Covered, except for: (1) diabetics; or (2) immuno-compromised patients.
- Growth Hormone Replacement Therapy is not Covered, except for: (1) treatment of absolute growth hormone deficiency in children whose epiphyses have not closed and who at initiation of therapy had a height of more than 2 standard deviations below the mean for chronological age; (2) growth hormone replacement therapy prior to renal transplant in children whose epiphyses have not closed and who also have chronic renal insufficiency (glomerular filtration rate (GFR) less than 60ml/minute/1.73 meter squared); (3) Members diagnosed with Turner syndrome; (4) Members diagnosed with Noonan Syndrome; (5) Members diagnosed with Prader-Willi syndrome and confirmed by appropriate genetic testing; (6) Members with decreased hypothalamic function due to any of the following reasons: pituitary tumor, pituitary surgical damage, trauma or cranial irradiation; or (7) Members under age 18 diagnosed with pituitary dwarfism.

Other drugs subject to specific limitations are included in the Prior Authorization list, the Quantity Limitations list, or noted in the Preferred Drug list. Current lists can be found at www.bcbst.com, or by calling the toll-free number shown on the membership ID card.

- Certain classes of Prescription Drugs in the Drug Formulary are subject to the Step Therapy Limitations, including, but not limited to: Opioid partial agonist-antagonists.

  Step Therapy is a form of Prior Authorization. When Step Therapy is required, You must initially try a drug that has been proven effective for most people with Your condition. This initial drug will be a Covered Generic Drug (if available) or a Preferred Brand Drug.

  However, if You have already tried an alternate, less expensive drug and it did not work, or if Your doctor believes that You must take the more expensive drug because of Your medical condition, Your doctor can contact the Plan to request an exception. If the request is approved, the Plan will cover the requested drug. For a complete list of drugs subject to this limitation, visit bcbst.com or call your customer service representative at the number on your membership ID card.
- Prescription and non-Prescription medical supplies, devices and appliances are not Covered, except for syringes used in conjunction with injectable medications or other supplies used in the treatment of diabetes and/or asthma;
- Immunizations or immunological agents, including but not limited to: (1) biological sera, (2) blood, (3) blood plasma; or (4) other blood products are not Covered, except for blood products required by hemophiliacs.
- Injectable drugs, are Covered only when: 1) intended for self-administration; or 2) defined by the Plan.
- Compound Drugs are only Covered when filled at a Network Pharmacy. The Network Pharmacy must submit the claim through the Plan's pharmacy benefit manager. The claim must contain a valid national drug code (NDC) number for all ingredients in the Compound Drug.
- Prescription Drugs that are commercially packaged or commonly dispensed in quantities less than a 30-calendar day supply (e.g. prescription items which are dispensed based on a certain quantity for a therapeutic regimen) will be subject to one Drug Copayment, provided the quantity does not exceed the FDA approved dosage for four calendar weeks.
- The Plan does not Cover Prescription Drugs prescribed for purposes other than for:

  a. indications approved by the FDA; or

b. off-label indications recognized through peer-reviewed medical literature.

If You abuse or over use pharmacy services outside of Our administrative procedures, We may restrict Your Pharmacy access. We will work with You to select a Network Pharmacy, and You can request a change in Your Network Pharmacy.

IV. EXCLUSIONS

In addition to the limitations and exclusions specified in the Group Agreement or EOC, benefits are not available under this Rider for the following:

- drugs that are prescribed, dispensed or intended for use while You are confined in a hospital, skilled nursing facility or similar facility, except as otherwise Covered in the EOC;
- any drugs, medications, Prescription devices, dietary supplements or vitamins, available over-the-counter that do not require a Prescription by Federal or State law; and/or Prescription Drugs dispensed in a doctor's office are excluded except as otherwise Covered in the EOC;
- any quantity of Prescription Drugs that exceed that specified by the Plan's P & T Committee;
- any Prescription Drug purchased outside the United States, except those authorized by Us;
- any Prescription dispensed by or through a non-retail Internet Pharmacy;
- contraceptives that require administration or insertion by a Provider (e.g., non-drug devices, implantable products such as Norplant, except injectables), except as otherwise Covered in the EOC;
- medications intended to terminate a pregnancy (e.g., RU-486);
- non-medical supplies or substances, including support garments, regardless of their intended use;
- artificial appliances;
- allergen extracts;
- any drugs or medicines dispensed more than one year following the date of the Prescription;
- Prescription Drugs You are entitled to receive without charge in accordance with any worker's compensation laws or any municipal, state, or federal program;
- replacement Prescriptions resulting from lost, spilled, stolen, or misplaced medications (except as required by applicable law);
- drugs dispensed by a Provider other than a Pharmacy;
- administration or injection of any drugs;
- Prescription Drugs used for the treatment of infertility;
- Prescription Drugs not on the Drug Formulary;
- anorectics (any drug or medicine for the purpose of weight loss and appetite suppression);
- nicotine replacement therapy and aids to smoking cessation including, but not limited to, patches;

- all newly FDA approved drugs prior to review by the Plan's P & T Committee. Prescription Drugs that represent an advance over available therapy according to the P & T Committee will be reviewed within at least six (6) months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug, will be reviewed within at least twelve (12) months after FDA approval;
- any Prescription Drugs or medications used for the treatment of sexual dysfunction, including but not limited to erectile dysfunction (e.g. Viagra), delayed ejaculation, anorgasmia and decreased libido;
- Prescription Drugs used for cosmetic purposes including, but not limited to: (1) drugs used to reduce wrinkles (e.g. Renova); (2) drugs to promote hair-growth; (3) drugs used to control perspiration; (4) drugs to remove hair (e.g. Vaniqa); and 5) fade cream products;
- Prescription Drugs used during the maintenance phase of chemical dependency treatment, unless Authorized by Us;
- FDA approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia;
- Specialty drugs used to treat hemophilia filled or refilled at an Out-of-Network Pharmacy;
- Compound drugs filled or refilled at an Out-of-Network Pharmacy;
- drugs used to enhance athletic performance;
- Experimental and/or Investigational Drugs;
- Provider-administered Specialty Drugs, as indicated on Our Specialty Drug list.
- Prescription Drugs or refills dispensed:
  - in quantities in excess of amounts specified in the Benefit payment section;
  - without Our Prior Authorization when required; or
  - that exceed any applicable Annual Maximum Benefit, or any other maximum benefit amounts stated in this Rider or the EOC.

These exclusions only apply to this Rider. Items that are excluded under the Rider may be Covered as medical supplies under the EOC. Please review your EOC carefully.

V. DEFINITIONS

1. **Annual Benefit Period** - The 12-month period under which Your benefits are administered, as noted in Attachment C: Schedule of Benefits.
2. **Average Wholesale Price** – A published suggested wholesale price of the drug by the manufacturer.
3. **Brand Name Drug** - a Prescription Drug identified by its registered trademark or product name given by its manufacturer, labeler or distributor.
4. **Compound Drug** - An outpatient Prescription Drug, which is not commercially prepared by a licensed pharmaceutical manufacturer in a dosage form approved by the food and drug administration (FDA) and that contains at least one ingredient classified as a Legend Prescription Drug.
5. **Drug Copayment/Copay** - the dollar amount specified in Section I of this Rider that You must pay directly to the Network Pharmacy at the time the covered Prescription

Drug is dispensed. The Drug Copayment is determined by the type of drug purchased, and must be paid for each Prescription Drug.

6. **Drug Formulary -** a list designating which Prescription Drugs and drug products are approved for reimbursement under a particular Prescirption Drug program. drug formularies are subject to periodic review and modification by the Plan.
7. **Experimental and/or Investigational Drugs –** Drugs or medicines, which are labeled: "Caution – limited by federal law to Investigational use."
8. **Generic Drug –**a Prescription Drug that has the same active ingredients, strength or concentration, dosage form and route of administration as a Brand Name Drug. The FDA approves each Generic Drug as safe and effective as a specific Brand Name Drug.
9. **Home Delivery Network –** BlueCross BlueShield of Tennessee's (BCBST) network of mail service pharmacy facilities.
10. **Home Delivery Retail Network –** BCBST's network of retail pharmacies that are permitted to dispense prescription drugs to BCBST Members on the same terms as pharmacies in the Home Delivery Network.
11. **Legend Drugs –** A drug that, by law, can be obtained only by Prescription and bears the label, "Caution: Federal law prohibits dispensing without a Prescription."
12. **Maintenance Drug –** Prescription Drugs most commonly used for selected disease states that are considered long term, chronic, and stable. The Plan maintains a list of Maintenance Drugs, which is reviewed periodically by Our Pharmacy and Therapeutics Committee. In keeping with accepted standards of medical practice, not all therapeutic classes of Drugs are included on the Maintenance Drug list.
13. **Maximum Allowable Charge –** The amount that the Plan, at its sole discretion, has determined to be the maximum amount payable for a Covered Service. That determination will be based upon the Plan's contract with a Network Provider or the amount payable based on the Plan's fee schedule for the Covered Service.
14. **Network Pharmacy -** a Pharmacy that has entered into a network pharmacy agreement with the Plan or its agent to legally dispense Prescription Drugs to You, either in person or through home delivery.
15. **Non Preferred Brand Drug or Elective Drug -** a Brand Name Drug which is not considered a Preferred Drug by the Plan. Usually there are lower cost alternatives to some Brand Name Drugs.
16. **Out-of-Network Pharmacy -** a Pharmacy that has not entered into a service agreement with BCBST or its agent to provide benefits under this Rider at specified rates to You.
17. **Pharmacy -** a state or federally licensed establishment that is physically separate and apart from the office of a physician or authorized Practitioner, and where Legend Drugs are dispensed by Prescription by a pharmacist licensed to dispense such drugs and products under the laws of the state in which he or she practices.
18. **Pharmacy and Therapeutics Committee or P&T Committee -** A panel of the Plan's participating pharmacists, Network Providers, medical directors and pharmacy directors that reviews medications for safety, efficacy and cost effectiveness. The P&T Committee evaluates medications for addition and deletion from the: 1) Drug Formulary; 2) Preferred Brand Drug list; 3) Maintenance Drug list; 4) Prior Authorization Drug list; and 5) Quantity Limitation list. The P&T Committee may also set dispensing limits on medications.

19. **Preferred Brand Drug -** Brand Name Drugs that the Plan has reviewed for clinical appropriateness, safety, therapeutic efficacy, and cost effectiveness. The Preferred Brand Drug list is reviewed at least annually by the P&T Committee.
20. **Prescription Drug -** a medication containing at least one Legend Drug that may not be dispensed under applicable state or federal law without a Prescription, and/or insulin.
21. **Prescription Contraceptive Drugs** – Prescription drug products that are indicated for the prevention of pregnancy.
22. **Prescription -** a written or verbal order issued by a physician or duly licensed Practitioner practicing within the scope of his or her licensure to a pharmacist for a drug, or drug product to be dispensed.
23. **Prior Authorization Drugs**- Prescription Drugs which are only eligible for reimbursement after prior authorization from the Plan as determined by the P&T Committee.
24. **Quantity Limitation –** Quantity limitations applied to certain Prescription Drug products as determined by the Pharmacy and Therapeutics Committee.
25. **Specialty Drugs** – Injectable, infusion and select oral medications that require complex care, including special handling, patient education and continuous monitoring. Specialty Drugs are listed on the Plan's Specialty Drug list. Specialty Drugs are categorized as provider-administered or self-administered.
26. **Step Therapy Limitations** – A form of Prior Authorization that begins drug therapy for a medical condition with the most cost-effective and safest drug therapy and progresses to alternate drugs only if necessary. Prescription drugs subject to Step Therapy guidelines are: (1) used only for patients with certain conditions; (2) Covered only for patients who have failed to respond to, or have demonstrated an intolerance to, alternate Prescription Drugs, as supported by appropriate medical documentation; and (3) when used in conjunction with selected Prescription Drugs for the treatment of your condition. For a complete list of drugs subject to this limitation, visit bcbst.com or call your customer service representative at the number on your membership ID card.

We will retain any refunds, rebates, reimbursements or other payments representing a return of monies paid for Covered Services under this Rider.

GENERIC DRUGS

Prescription drugs are classified as brand or generic. A given drug can change from brand to generic or from generic to brand. Sometimes a given drug is no longer available as a Generic Drug. These changes can occur without notice. If You have any questions, please contact Our customer service representatives.

The Preferred Drug list, the Prior Authorization list, the Specialty Drug list, the Quantity Limitations list, the Maintenance Drug list, and the Limited Formulary Drug list are subject to change. Current lists can be found at www.bcbst.com, or by calling the toll-free number shown on the membership ID card.

All terms and conditions set forth in the Group Agreement and all prior Riders, Amendments and Exhibits remain in full force and effect. If this Rider conflicts with the terms and conditions in the Group Agreement, the terms of this Rider will prevail. Payment of premiums and/or fees on or after the effective date of this Rider will constitute acceptance by the Employer.

BEHAVIORAL HEALTH SERVICES RIDER

BLUECROSS BLUESHIELD OF TENNESSEE, INC.
1 CAMERON HILL CIRCLE
CHATTANOOGA, TN 37402

Notwithstanding any Evidence of Coverage (EOC) provision, amendment, or endorsement to the contrary, the EOC is amended to include the attached Behavioral Health Services Rider.

A. INTRODUCTION

This Rider provides Coverage for inpatient and outpatient services for Medically Necessary and Appropriate care and treatment of behavioral health disorders

B. PRIOR AUTHORIZATION REQUIREMENTS

Prior Authorization is required for:

1. All inpatient levels of care. Inpatient levels of care include Acute care, residential care, partial hospital care, and intensive outpatient programs.
2. Electro-convulsive therapy (ECT) provided on an inpatient or outpatient basis.
3. Outpatient visits do not require Prior Authorization.

Call the toll-free number indicated on the back of Your membership ID card if You have questions about Prior Authorization requirements for Behavioral Health Services.

C. COVERED SERVICES

Benefits are available for Medically Necessary and Appropriate treatment of mental health and substance abuse disorders (behavioral health conditions) characterized by abnormal functioning of the mind or emotions and in which psychological, emotional or behavioral disturbances are the dominant features.

a. Inpatient and outpatient services for care and treatment of mental health disorders and substance abuse disorders.

D. EXCLUSIONS

a. Pastoral Counseling
b. Marriage and family counseling without a behavioral health diagnosis.
c. Vocational and educational training and/or services.
d. Custodial or domiciliary care.
e. Conditions without recognizable ICD-9 diagnostic classification, such as adult child of alcoholics (ACOA), and co-dependency and self-help programs.
f. Sleep disorders.
g. Services related to mental retardation.
h. Habilitative as opposed to rehabilitative services, i.e., services to achieve a level of functioning the individual has never attained.
i. Court ordered examinations and treatment, unless Medically Necessary.

Unlimited

j. Pain management.
k. Hypnosis or regressive hypnotic techniques.
l. Charges for telephone consultations, missed appointments, completion of forms, or other administrative services.

All terms and conditions set forth in the Group Agreement and all prior Riders, Amendments and Exhibits remain in full force and effect. If this Rider conflicts with the terms and conditions in the Group Agreement, the terms of this Rider will prevail. Payment of premiums and/or fees on or after the effective date of this Rider will constitute acceptance by the Employer.

IMPORTANT NOTE: All inpatient treatment (including acute, residential, partial hospitalization and intensive outpatient treatment) requires Prior Authorization. If You receive inpatient treatment, including treatment for substance abuse, that did not receive Prior Authorization, and You sign a Provider's waiver stating that you will be responsible for the cost of the treatment, You will not receive Plan benefits for the treatment. You will be financially responsible, according to the terms of the waiver.

Benefit percentages apply to BCBST Maximum Allowable Charge. In-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.	**In-Network Benefits for Covered Services received from Network Providers**		**Out-of-Network Benefits for Covered Services received from Out-of-Network Providers**
Inpatient Behavioral Health Services: Inpatient Treatment (including Acute care treatment, partial hospital treatment, residential treatment, electro-convulsive therapy (ECT) and intensive outpatient treatment) and treatment in halfway houses or group homes. 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	80% after deductible		60% of the Maximum Allowable Charge after Deductible
Practitioner charges	80% after deductible		60% of the Maximum Allowable Charge after Deductible
Outpatient Behavioral Health Services: Outpatient treatment (outpatient visits to professionals provided in a Practitioner's office or community mental health center).	100% after $20 Copayment		60% of the Maximum Allowable Charge after Deductible

VISION CARE RIDER

BLUECROSS BLUESHIELD OF TENNESSEE, INC.
1 CAMERON HILL CIRCLE
CHATTANOOGA, TN 37402

Notwithstanding any Group Agreement provision, amendment, or endorsement to the contrary, it is agreed that the Evidence of Coverage is amended to include the following provision:

VISION CARE RIDER 2

Benefits are available for routine vision care as follows:

1 vision exam per Annual Benefit Period	$20 Copayment
1 set of lenses including bi-focal, tri-focal, etc., every Annual Benefit Period	100% up to $85
Contact lenses in lieu of eyeglasses every Annual Benefit Period	100% up to $150
1 set of frames every 2 Annual Benefit Periods	100% up to $75

RESTRICTIONS

Sunglasses will be handled as any other lens.

EXCLUSIONS

Benefits will not be provided for the following services, supplies or charges:

1. Charges for vision testing examinations, lenses and frames ordered while insured but not delivered within 60 days after Coverage is terminated.
2. Charges for sunglasses, photosensitive, anti-reflective or other optional charges when the charge exceeds the amount allowable for regular lenses.
3. Charges filed for procedures determined by the Plan to be special or unusual, (i.e. orthoptics, vision training, subnormal vision aids, aniseikonic lenses, tonography, corneal refractive therapy, etc.)
4. Charges for lenses that do not meet the Z80.1 or Z80.2 standards of the American National Standards Institute.
5. Charges in excess of the Maximum Allowable Charge as established by the Plan.

All terms and conditions set forth in the Group Agreement and all prior Riders, Amendments and Exhibits remain in full force and effect. If this Rider conflicts with the terms and conditions in the Group Agreement, the terms of this Rider will prevail. Payment of premiums and/or fees on or after the effective date of this Rider will constitute acceptance by the Employer.

BLUECROSS BLUESHIELD OF TENNESSEE, INC.

Joan C. Harp
President Commercial Business & Established Markets

EVIDENCE OF COVERAGE

ATTACHMENT D: ELIGIBILITY

Any Employee of the Group and his/her family dependents, who meet the eligibility requirements of this Section, will be eligible for Coverage under the Group Agreement if properly enrolled for Coverage and upon payment of the required Premium for such Coverage. If there is any question about whether a person is eligible for Coverage, the Plan shall make final eligibility determinations.

A. Subscriber

To be eligible to enroll as a Subscriber, You must:

1. Be a full-time or part-time Employee of the Group who is Actively at Work; and
2. Satisfy all eligibility requirements of the Group Agreement; and
3. Enroll for Coverage from the Plan by submitting a completed and signed Enrollment Form to Your Group representative.
4. Be a permanent part-time Employee who works at least 25 hours per week.
5. Satisfy any new Employee eligibility period required by the Employer.

For leaves of absence, please refer to the Continuation of Coverage section of this EOC.

B. Covered Dependents

You can apply for Coverage for Your dependents. You must list Your dependents on the Enrollment Form. To qualify as a Covered Dependent, each dependent must meet all dependent eligibility criteria established by the Employer, satisfy all eligibility requirements of the Group Agreement; and be either:

1. The Subscriber's current spouse as recognized by Tennessee law; or the law of California; or
2. The Subscriber's or Subscriber's spouse's: (1) natural child; (2) legally adopted child (including children placed with You for the purpose of adoption); (3) step-child(ren); or (4) children for whom You or Your spouse are legal guardians; who are less than 26 years old; or
3. A child of the Subscriber or the Subscriber's spouse for whom a Qualified Medical Child Support Order has been issued; or
4. An Incapacitated Child of the Subscriber or Subscriber's spouse.

Dependents who permanently reside outside the United States are not eligible for Coverage under the EOC.

Subscribers who are not U.S. citizens, do not reside in the United States, and work at an Employer's location not located in the United States, are not eligible for Coverage under the EOC.

The Plan's determination of eligibility under the terms of this provision shall be conclusive.

The Plan reserves the right to require proof of eligibility including, but not limited to, a certified copy of any Qualified Medical Child Support Order or certification of full-time student status.

C. Loss of Eligibility

Coverage for a Member who has lost his/her eligibility shall automatically terminate at 12:00 midnight on either: (1) the last day of the month during which that loss of eligibility occurred; or (2) the day that loss of eligibility occurred. Check with the Group to see which termination date will apply to You.

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

www.bcbst.com

BENEFIT QUESTIONS?

Call the Customer Service
Number on your I.D. Card

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