



Health Benefit Plan
Evidence of Coverage

CLARKSVILLE-MONTGOMERY
COUNTY EMPLOYEES INSURANCE
TRUST
Active Employees



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

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

COMM-662 (2/12)
Group

**Employer Sponsored Plan
Administered by BlueCross BlueShield of Tennessee, Inc. (BCBST)**

Notice to Member:

Regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) require that a Member be given credit under certain conditions for the time covered under previous health benefit program coverage.

Such “Creditable Coverage” may be used to reduce the waiting period for Pre-existing Conditions. However, it will be the Member’s responsibility to advise the Employer of any Creditable Coverage and provide any required documentation. The Employer, in turn, will advise the Member as to the date of the Pre-existing Condition limitation ends.

NOTICE

PLEASE READ THIS EVIDENCE OF COVERAGE CAREFULLY AND KEEP IT IN A SAFE PLACE FOR FUTURE REFERENCE. IT EXPLAINS YOUR BENEFITS AS ADMINISTERED BY BLUECROSS BLUESHIELD OF TENNESSEE, INC. IF YOU HAVE ANY QUESTIONS ABOUT THIS EVIDENCE OF COVERAGE OR ANY OTHER MATTER RELATED TO YOUR MEMBERSHIP IN THE PLAN, PLEASE WRITE OR CALL US AT:

**CUSTOMER SERVICE DEPARTMENT
BLUECROSS BLUESHIELD OF TENNESSEE, INC.
1 CAMERON HILL CIRCLE.
CHATTANOOGA, TENNESSEE 37402
(800) 565-9140**

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INTRODUCTION

This Evidence of Coverage (this “EOC”) is included in the Summary Plan Description document (SPD) created by the Employer (listed on the cover of this EOC) as part of its Employee welfare plan (the “Plan”). References in this EOC to the “Administrator” mean BlueCross BlueShield of Tennessee, Inc., or BCBST. The pronouns “we”, “us”, and “our” used throughout this EOC refer to BCBST. The Employer has entered into an Administrative Services Agreement (ASA) with BCBST for it to administer the claims Payments under the terms of the SPD, and to provide other services. BCBST does not assume any financial risk or obligation with respect to Plan claims. BCBST is not the Plan Sponsor, the Plan Administrator or the Plan Fiduciary. The Employer is the Plan Fiduciary, the Plan Sponsor and the Plan Administrator. These ERISA terms are used in this EOC to clarify their meaning, even though the Plan is not subject to ERISA. Other federal laws may also affect Your Coverage. To the extent applicable, the Plan complies with federal requirements.

This EOC describes the terms and conditions of Your Coverage through the Plan. It replaces and supersedes any Certificate or other description of benefits You have previously received from the Plan.

PLEASE READ THIS EOC CAREFULLY. IT DESCRIBES THE RIGHTS AND DUTIES OF MEMBERS. IT IS IMPORTANT TO READ THE ENTIRE EOC. CERTAIN SERVICES ARE NOT COVERED BY THE PLAN. OTHER COVERED SERVICES ARE OR MAY BE 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.

While the Employer has delegated discretionary authority to make any benefit or eligibility determinations to the administrator, the Employer also has the authority to make any final Plan determination. The Employer, as the Plan Administrator, and BCBST also have the authority to construe the terms of Your Coverage. The Plan and BCBST shall be

deemed to have properly exercised that authority unless it abuses its discretion when making such determinations, whether or not the Employer’s benefit plan is subject to ERISA.

ANY GRIEVANCE RELATED TO YOUR COVERAGE UNDER THIS EOC SHALL BE RESOLVED IN ACCORDANCE WITH THE “GRIEVANCE PROCEDURE” SECTION OF THIS EOC.

In order to make it easier to read and understand this EOC, defined words are capitalized. Those words are defined in the “DEFINITIONS OF TERMS” section of this EOC.

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

INDEPENDENT LICENSEE OF THE BLUECROSS BLUESHIELD ASSOCIATION

BCBST is an independent corporation operating under a license from the BlueCross BlueShield Association (the “Association”). That license permits BCBST to use the Association’s service marks within its assigned geographical location. BCBST is not a joint venturer, agent or representative of the Association nor any other independent licensee of the Association.

RELATIONSHIP WITH NETWORK PROVIDERS

1. Independent Contractors

Network Providers are not Employees, agents or representatives of the administrator. Such Providers contract with the administrator, which has agreed to pay them for rendering Covered Services to Members. Network Providers are solely responsible for making all medical treatment decisions in consultation with their Member-patients. The Employer and the administrator do not make medical treatment decisions under any circumstances.

While the administrator has the authority to make benefit and eligibility

determinations and interpret the terms of Your Coverage, the Employer, as the Plan Administrator as that term is defined in ERISA, has the discretionary authority to make the final determination regarding the terms of Your Coverage (“Coverage Decisions”). Both the administrator and the Employer make Coverage Decisions based on the terms of this EOC, the ASA, the administrator’s participation agreements with Network Providers, the administrator’s internal guidelines, policies, procedures, and applicable State or Federal laws.

The administrator’s participation agreements permit Network Providers to dispute 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 Coverage Decisions to You, upon request, if You decide to request that the administrator reconsider a Coverage Decision.

The administrator has established various incentive arrangements to encourage Network Providers to provide Covered Services to You in an appropriate and cost effective manner. You may request information about Your Provider’s Payment arrangement by contacting the administrator’s customer service department.

2. Termination of Providers’ Participation

The administrator 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 administrator does not promise that any specific Network Provider will be available to render services while You are covered.

3. Provider Directory

A Directory of Network Providers is available at no additional charge to You. You may also check to see if a Provider is in Your Plan’s Network by going online to www.bcbst.com.

NOTIFICATION OF CHANGE IN STATUS

Changes in Your status can affect the service under the Plan. To make sure the Plan works correctly, please notify the customer service department at the number listed on the Subscriber’s membership ID card when You change:

- name;
- address;
- telephone number;
- employment; or
- status of any other health coverage You have.

Subscribers must notify the administrator of any eligibility or status changes for themselves or Covered Dependents, including:

- the marriage or death of a family member;
- divorce;
- adoption;
- birth of additional dependents; or
- termination of employment.

**SCHEDULE OF BENEFITS -
Clarksville – Montgomery County Employees Insurance Trust**

Group Number: 90045

Benefits Effective: September 1, 2012

Benefits Available

A Member is entitled to benefits for Covered Services as specified in this Schedule of Benefits. Benefits shall be determined according to the ASA terms in effect when a service is received. Benefits may be amended at any time in accordance with applicable provisions of the ASA. Under no circumstance does a Member acquire a vested interest in continued receipt of a particular benefit or level of benefit.

Calculation of Coinsurance

As part of the efforts to contain health care costs, BCBST has negotiated agreements with Hospitals under which BCBST receives a discount on Hospital bills. In addition to such discounts, BCBST also has some agreements with Hospitals under which payment is based upon other methods of payment (such as flat rates, capitation or per diem amounts).

Your Coinsurance will be based upon the same dollar amount of payment that BCBST uses to calculate its portion of the claims payment to the Hospital, regardless of whether Our payment is based upon a discount or an alternative method of payment.

Member's Responsibility

Prior Authorization may be required for certain services. Please have Your Physician contact BCBST at the telephone number shown on the Subscriber's membership ID card before services are provided. Otherwise, Your benefits may be reduced or denied.

The Dependent Child Limiting Age will be to age 26 (Dependent coverage will end on the last day of the month after reaching the Dependent Child Limiting Age.)

DEDUCTIBLE

Deductible to be applied to:	Network Provider	Out-of-Network Provider
Individual Deductible Maximum	\$350	\$350
Two-Person Deductible Maximum	\$700	\$700
Family Deductible Maximum	\$875	\$875

Combined - Network/ Out-of-Network Deductibles:	
Individual	\$350
Two-Person	\$700
Family	\$875

The Deductible will be waived for accidental injuries.

COINSURANCE:

Coinsurance percentages will be applied to the lesser of the negotiated fee or other basis for Our reimbursement for Covered Services.

Benefits available for Covered Services received from an Out-of-Network Provider will be significantly less than benefits available for services received from a Network Provider. For services received from an Out-of-Network Provider, the Member must pay the applicable Coinsurance, as well as the difference between the Out-of-Network Provider’s Billed Charges and the Maximum Allowable Charge.

Coinsurance to be applied to:	Network Provider	Out-of-Network Provider
All Covered Services after Deductible has been satisfied (unless otherwise specified)	90%	70%
Inpatient Rehabilitation Services, limited to 100 days per calendar year.	90%	70%
Preventive Services Under age 6	100%	70% after Deductible has been satisfied
Preventive Services Age 6 and over	100%	70% after Deductible has been satisfied
Lactation counseling by a trained provider during pregnancy or in the post-partum period. Limited to one visit per pregnancy.	100%	70% of the Maximum Allowable Charge after Deductible
Manual Breast Pump, limited to one per pregnancy	100%	70% of the Maximum Allowable Charge after Deductible
FDA-approved contraceptive methods, sterilization procedures and counseling for women with reproductive capacity.	100%	70% of the Maximum Allowable Charge after Deductible
Coinsurance percentages will be applied to the lesser of the negotiated fee or other basis for Our reimbursement of Covered Services.		

OUT-OF-POCKET MAXIMUM:

	Network	Out-of-Network:
Individual	\$1,350	\$4,050
2-Person	\$2,700	\$8,100
Family	\$2,700	\$8,100

Psychiatric Care Maximums	Network Provider	Out-of-Network Provider
Inpatient Benefits payable per Benefit Period limited to 30 days	80%	60%
Outpatient Benefits payable per Benefit Period limited to 35 visits	50%	50%
Benefits will not be provided for more than two Inpatient stays for Substance Abuse Treatment.		

Mental Health Medication Management Benefit: Outpatient treatment visits for Medication Management do not count toward the number of mental health outpatient visits per year. Medication Management means pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy.

Two (2) Residential Treatment days for one (1) inpatient day.

Schedule of Pharmacy Prescription Drug Copayments

Separate Brand Name Drug Deductible (does not apply to satisfying any Plan Deductible, Coinsurance, or Out-of-Pocket Maximums.	\$75.00 per Member per Calendar Year		
Prescription Drug Out-of-Pocket (includes Brand Name Drug Deductible) Once You have met Your Annual Benefit Period Drug Out-of-Pocket, benefits are payable at 100% for Covered Services You incur during the remainder of that Annual Benefit Period.	\$750.00 per Member per Calendar Year		
	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	100%/90%/80%	N/A	N/A
Mail Order Network	100%/90%/80%	100%/90%/80%	100%/94%/87%
Plus90 Network	100%/90%/80%	100%/90%/80%	100%/94%/87%
Out-of-Network	You pay all costs, then file a claim for reimbursement.		

Prescriptions are filled in 30-day supplies at all network retail pharmacies; 90-day supplies are available through the Mail Order Network and the Plus90 Network. See www.bcbst.com to locate network pharmacies and to learn more about mail order.

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

Your Copayments vary based on the days supply dispensed as shown above.

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

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

Organ Transplant Services			
Organ Transplant Services, all transplants except kidney	In-Transplant Network benefits: 90% after Network Deductible, Network Out-of-Pocket Maximum applies.	Network Providers not in Our Transplant Network: 90% 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 Transplant Maximum Allowable Charge (TMAC), after Out-of-Network Deductible, Out-of-Network Out-of-Pocket Maximum applies, amounts over TMAC do not apply to the Out-of-Pocket and are not Covered.
Organ Transplant Services, kidney transplants	Network Providers: 90% 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.
<i>Network Providers not in Our Transplant Network include Network Providers in Tennessee and BlueCard PPO Providers outside Tennessee.</i>			

The Annual Maximum Amount Payable for Network and/or Out-of-Network Provider Services is \$2,000,000.

OTHER PROVISIONS

The waiting period before benefits are payable for a Pre-existing Condition will be 12 months. This period may be reduced by any Creditable Coverage.

ADDITIONAL BENEFITS

When a Network Provider furnishes the following services the Deductible will not apply. Benefits will be provided at 100% of the Maximum Allowable Charge:

- Pre-admission Testing Expenses
- Second Surgical Opinion Consultation Expenses within three months of the first opinion
- Home Health Care Agency Expenses
- Skilled Nursing Facility Expenses

SPECIAL PROVISIONS

1. Benefits will be payable at 50% for covered expenses rendered in connection with correction of nerve interference and its effects by manual or mechanical means where the interference results from or is related to distortion, misalignment, or subluxation of or in the vertebral column (spinal manipulation therapy). Services limited to 30 visits per Calendar Year. The 50% Coinsurance will not apply to any Out-of-Pocket maximums.
2. Benefits will be available, subject to the Deductible and Coinsurance, for Orthotics for the foot, including shoe inserts, braces, molded shoes or appliances.
3. Benefits will be available for the office visit in connection with an annual cervical cancer screening.
4. Benefits will be available for annual screening for men treated for prostate cancer, men over 45 with enlarged prostates, and for men of any age with prostate nodules or other irregularities. The PSA test will be the primary screening tool of men over 50 and the transrectal ultrasound will be covered for those with elevated PSA levels.
5. Benefits will be available, beginning at age 50, for colorectal screenings as follows:
 - a. Yearly fecal occult blood test (FOBT).
 - b. Flexible sigmoidoscopy every 5 years.
 - c. Yearly FOBT and flexible sigmoidoscopy every 5 years (preferred over either test alone).
 - d. Double contrast barium enema every 5 years.
 - e. Colonoscopy every 10 years.
6. Benefits will be available, subject to the Deductible and Coinsurance and the criteria below, for the following four surgical procedures for the treatment of morbid obesity:
 - a. Vertical banded gastroplasty accompanied by gastric stapling. Restricts the size of the stomach using a stapling technique. There is no rearrangement of the intestinal anatomy.
 - b. Gastric segmentation along the vertical axis with a Roux-en-Y bypass with distal anastomosis placed in the jejunum. Restricts the size of the stomach by stapling shut 90% of the lower stomach. The proximal intestinal anatomy is rearranged, thereby bypassing the duodenum.
 - c. Gastric banding. Involves placing a gastric band around the outside of the stomach. The stomach is not entered.
 - d. Duodenal switch/biliopancreatic bypass. A variant of the biliopancreatic bypass. Instead of performing a distal gastrectomy, a "sleeve" gastrectomy is performed along the vertical axis of the stomach. The sleeve gastrectomy decreases the volume of the stomach and the parietal cell mass. This procedure is only appropriate for persons with a BMI in excess of 60.

The following criteria must be met before benefits are available for the procedures listed above:

- a. Presence of morbid obesity that has persisted for a least five (5) years, defined as either:
- Body mass index (BMI) exceeding forty (40); or
 - More than one hundred (100) pounds over one's ideal body weight as provided in the 1983 Metropolitan Life Height and Weight table; or
 - BMI greater than thirty-five (35) in conjunction with the following severe co-morbidities that are likely to reduce life expectancy:
 - Coronary artery disease; or
 - Type 2 diabetes mellitus; or
 - Obstructive sleep apnea; or
 - Three or more of the following cardiac risk factors:
 - (1) Hypertension (BP>140 mmHg systolic and/or 90mmHg diastolic)
 - (2) Low high-density lipoprotein cholesterol (HDL less than 40mg/dL)
 - (3) Elevated low-density lipoprotein cholesterol (LDL>100 mg/dL)
 - (4) Current cigarette smoking
 - (5) Impaired glucose tolerance (2 hour blood glucose>140 mg/dL on an oral glucose tolerance test)
 - (6) Family history early cardiovascular disease in first degree relative (myocardial infarction at age under fifty (50) in male relative or at age under sixty-five (65) for a female relative)
 - (7) Age greater than forty-five (45) years in men and fifty-five (55) years in women; or
 - Body Mass Index exceeding 60 for consideration of the duodenal switch/biliopancreatic bypass procedure.
- b. History of failure of medical/dietary therapies (including low calorie diet, increased physical activity and behavioral reinforcement). This attempt at conservative management must be within two (2) years prior to surgery, and must be documented by an attending physician who does not perform bariatric surgery. (Failure of conservative therapy is defined as an inability to lose more than ten (10) percent of body weight over a six (6) month period and maintain weight loss).
- c. There must be documentation of Medical evaluation of the individual for the condition of morbid obesity and/or its co-morbidities by a physician other than the operating surgeon and his/her associates, and documentation that this evaluating physician concurs with the recommendation for bariatric surgery.

Prior Authorization is required. BCBST will determine if all the criteria have been met before approving surgery.

7. Benefits are available for dietary counseling for medical conditions other than diabetes, limited to 6 visits per Benefit Period and payable as Preventive Services.
8. Benefits are available for tobacco cessation counseling, limited to 8 visits per Benefit Period and payable as Preventive Services.

HEALTHY FOCUS PROGRAM

Healthy Focus Personal Health Coaching is a voluntary program available through the Employer and managed in association with a disease and health management organization. This program offers You unlimited access to a health coach – registered nurse – 24/7/365 for any chronic health condition or symptom. Through this program, You may receive outreach from our health coaches. You can also receive extra resources and personalized attention to help manage chronic health conditions and

help You take better care of Yourself. Call toll free 1-800-818-8581 for chronic condition management, decision support assistance, or about any type of health condition or symptom related question.

PRESCRIPTION DRUG PROGRAM

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

1. Covered Services

- a. 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 the Schedule of Benefits.

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

2. Limitations

- a. 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.
- b. 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.
- c. Certain drugs are not Covered except when prescribed under specific circumstances as determined by the P & T Committee.
- d. Injectable drugs, except when: (1) intended for self-administration; or (2) defined by the Plan;
- e. Compound Drugs are Covered only when filled at a Network Pharmacy. The Network Pharmacy must submit the claim through the administrator's pharmacy benefit manager. The claim must contain a valid national drug code (NDC) number for all ingredients in the Compound Drug. The highest tier Coinsurance will apply to all claims for Compound Drugs.
- f. The Plan does not Cover Prescription Drugs prescribed for purposes other than for:

- i. indications approved by the FDA; or
 - ii. off-label indications recognized through peer-reviewed medical literature.
- g. 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.
- h. 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. 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 administrator to request an exception. If the request is approved, the administrator will Cover the requested drug.
- i. 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.
 - j. 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.

3. Exclusions

In addition to the limitations and exclusions specified in the EOC, benefits are not available for the following:

- a. any Prescription Drug that is not on the Preferred Formulary;
- b. 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;
- c. 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;
- d. any quantity of Prescription Drugs that exceeds that specified by the administrator's P & T Committee;
- e. any Prescription Drug purchased outside the United States, except those authorized by Us;
- f. 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;
- g. medications intended to terminate a pregnancy (e.g., RU-486);
- h. non-medical supplies or substances, including support garments, regardless of their intended use;
- i. artificial appliances;
- j. allergen extracts;
- k. any drugs or medicines dispensed more than one year following the date of the Prescription;
- l. Prescription Drugs You are entitled to receive without charge in accordance with any worker's compensation laws or any municipal, state, or federal program;
- m. replacement Prescriptions resulting from lost, spilled, stolen, or misplaced medications (except as required by applicable law);
- n. drugs dispensed by a Provider other than a Pharmacy or dispensing physician;

- o. administration or injection of any drugs or immunizations;
- p. Prescription Drugs used for the treatment of infertility;
- q. anorectics (any drug or medicine for the purpose of weight loss and appetite suppression);
- r. Over-the-counter (OTC) nicotine replacement therapy and aids to smoking cessation including, but not limited to, patches;
- s. all newly FDA approved drugs prior to review by the administrator'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;
- t. 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;
- u. 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;
- v. Prescription Drugs used during the maintenance phase of chemical dependency treatment, unless Authorized by Us;
- w. 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;
- x. Specialty Drugs used to treat hemophilia filled or refilled at an Out-of-Network Pharmacy;
- y. Compound drugs filled or refilled at an Out-of-Network Pharmacy;
- z. drugs used to enhance athletic performance;
- aa. Experimental and/or Investigational Drugs;
- bb. Provider-administered Specialty Drugs, as indicated on Our Specialty Drugs list; and
- cc. 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 the EOC.

These exclusions only apply to Prescription Drug Benefits. Items that are excluded under Prescription Drug Benefits may be Covered as medical supplies under the EOC. Please review Your EOC carefully.

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 consumer advisors.

The drug lists referenced in this section 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.

4. Definitions

- a. **Average Wholesale Price** – A published suggested wholesale price of the drug by the manufacturer.
- b. **Brand Name Drug** - a Prescription Drug identified by its registered trademark or product name given by its manufacturer, labeler or distributor.
- c. **Brand Name Prescription Contraceptive Drug Deductible** - the amount that You must pay before benefits are provided for Brand Name Prescription Contraceptive Drugs. The Brand Name Prescription Contraceptive Drug Deductible will not apply toward satisfying any other Deductible or Out-of-Pocket Maximum.
- d. **Compound Drug** – An outpatient Prescription Drug that 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 Drug.
- e. **Covered Drug Expenses** – Covered Drug Expenses will be the lesser of: (a) the Maximum Allowable Charge (MAC) plus any dispensing fees and applicable sales tax; or (b) the Average Wholesale Price less any negotiated discounts plus any applicable dispensing fees and applicable sales tax.
- f. **Drug Copayment** - the amount specified in the Schedule of Benefits that You must pay directly to the Network Pharmacy when 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.
- g. **Drug Formulary** - a list designating which Prescription Drugs and drug products are approved for reimbursement under a particular Prescription Drug program. This list is subject to periodic review and modification by the administrator.
- h. **Experimental and/or Investigational Drugs** – Drugs or medicines that are labeled: “Caution – limited by Federal law to Investigational use.”
- i. **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.
- j. **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.”
- k. **Mail Order Network** – BlueCross BlueShield of Tennessee’s (BCBST) network of mail service pharmacy facilities.
- l. **Managed Dosage Limitation** – Quantity limitations applied to certain Prescription Drug products as determined by the Pharmacy and Therapeutics Committee.
- m. **Maximum Allowable Charge** – the amount that the administrator, at its sole discretion, has determined to be the maximum amount payable for a Covered Service. That determination will be based upon the administrator’s contract with a Network Provider or the amount payable based on the administrator’s fee schedule for the Covered Service.
- n. **Network Pharmacy** - a Pharmacy that has entered into a network pharmacy agreement with the administrator or its agent to legally dispense Prescription Drugs to You, either in person or through mail order.
- o. **Non-Preferred Brand Drug or Elective Drug** - a Brand Name Drug that is not considered a Preferred Drug by the administrator. Usually there are lower cost alternatives to some Brand Name Drugs.
- p. **Out-of-Network Pharmacy** - a Pharmacy that has not entered into a service agreement with the administrator or its agent to provide benefits at specified rates to You.

- q. **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.
- r. **Pharmacy and Therapeutics Committee or P&T Committee**– A panel of 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) Prior Authorization Drugs list; and (4) Quantity Limitation list. The P&T Committee may also set dispensing limits on medications.
- s. **Plus90 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 Mail Order Network.
- t. **Preferred Brand Drug** - Brand Name Drugs that the administrator 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.
- u. **Preferred Formulary** – A list of specific generic and brand name Prescription Drugs covered by the Plan subject to Quantity Limitations, Prior Authorization and Step Therapy. The Preferred Formulary is subject to periodic review and modification at least annually by the administrator’s P&T Committee. The Preferred Formulary is available for review at www.bcbst.com, or by calling the toll-free number shown on Your membership ID card.
- v. **Prescription** - a written or verbal order issued by a physician or duly licensed Practitioner practicing within the scope of his or her licensure and authorized by law to a pharmacist or dispensing physician for a drug, or drug product to be dispensed.
- w. **Prescription Contraceptive Drugs** - Prescription Drug products that are indicated for the prevention of pregnancy.
- x. **Prescription Contraceptive Drug List** – A list of Prescription Contraceptive Drugs covered under this section.
- y. **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.
- z. **Prior Authorization Drugs**- Prescription Drugs that are only eligible for reimbursement after Prior Authorization as determined by the P&T Committee.
- aa. **Quantity Limitation** – Quantity limitations applied to certain Prescription Drug products as determined by the P&T Committee.
- bb. **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 administrator’s Specialty Drug list. Specialty Drugs are categorized as provider-administered or self-administered.
- cc. **Step Therapy** – 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.

SECTION I - ELIGIBILITY

COVERAGE FOR YOU

This EOC describes the benefits You may receive under Your Plan. You are called the Subscriber or Member.

COVERAGE FOR YOUR DEPENDENTS

If a Subscriber is covered by this Plan, he or she may enroll Eligible Dependents. The Subscriber and his or her Covered Dependents are also called Members. The names of Dependents for whom application for coverage is made must be listed on the application on file in Our records. Subsequent applications for Dependents must be submitted to BCBST in writing.

TYPES OF COVERAGE AVAILABLE

Individual - Employee only

Two-Person - Employee and one Eligible Dependent

Family - Employee and all eligible Dependents

ELIGIBLE EMPLOYEES

To be eligible for coverage an Employee must:

- be a permanent Employee regularly scheduled to work a minimum of 15 hours per week; or
- Be a Board Members who applied for coverage on or before July 1, 2001.

ELIGIBLE RETIRED AND DISABILITY RETIRED EMPLOYEES

To be eligible for coverage a Retired or Disability Retired Employee must:

- be a service or early Retiree under the Tennessee Consolidated Retirement System (TCRS) who terminated employment and who is eligible to receive TCRS retirement benefits and who has:
 - twenty or more total years of employment with three years of medical coverage in this Plan immediately prior to retirement, provided the period of time between the Employee's final termination date and the date retirement benefits

commence (retirement date) may be up to five years; or

- ten, but less than 20, total years of employment, with three continuous years of medical coverage in this Plan immediately prior to retirement, provided the date retirement benefits commence (retirement date) must immediately follow the Employee's date of final termination from employment.

Employees approved under these provisions may continue coverage until the earlier of the Employee's 65th birthday or he/she qualifies for Medicare. They must elect to continue medical coverage within 31 days of application for retirement benefits and will pay the appropriate contribution for Retirees as set by the Insurance Trust. Service years with CMCSS will determine the level of contribution to be made by Employer. Said contribution will not exceed 10 years. For Employees who elected Two-Person or Family coverage, coverage may be continued on (1) their eligible Dependent Spouse until the earlier of the Dependent Spouse's attainment of age 65 or he/she qualifies for Medicare, and (2) their eligible Dependent Children until the child reaches the Dependent Child Limiting Age or qualifies for Medicare.

- If TCRS Retirees do not elect to continue medical coverage within the 31-day application period for retirement benefits, they may continue coverage only if approved as a Late Enrollee by BlueCross BlueShield of Tennessee.
- Retired Employees must remain continuously enrolled in the Clarksville group plan after retirement. If they retire, then decide to teach at another school system, they cannot drop coverage and later re-enroll in the Clarksville Plan.
- For Employees who have attained age 65 or qualified for Medicare when applying for retirement benefits, they can continue Two-Person or Family coverage on their eligible Dependents only if they had elected such coverage prior to the time retirement benefits were applied for.

- Spouses of TCRS Retirees can be covered under the Plan only if the TCRS Retiree was covered under the plan.
- If a TCRS Retiree was covered under the Plan and elected single coverage at the time retirement benefits were applied for, and subsequently acquired new Dependents as defined by the Dependent eligibility guidelines of this Plan, he/she can elect to cover these Dependents until the earlier of the TCRS Retiree's attainment of age 65 or he/she qualifies for Medicare.
- If a TCRS Retiree should predecease or divorce his/her Spouse, and subsequently remarry while covered under the Plan, he/she can cover himself/herself and his/her new Dependents until the earlier of his/her attainment of age 65 or he/she qualifies for Medicare.
- If a TCRS Retiree's Spouse should predecease or divorce the Retiree, and subsequently remarries while covered under the Plan, he/she can continue coverage on himself/herself and his/her eligible Dependents under the earlier of the Spouse's attainment of age 65 or he/she qualifies for Medicare.
- If a TCRS Retiree should initially qualify for Medicare, then lose Medicare coverage as a result in improvement in his/her medical condition, he/she will be allowed to re-enroll in the Plan until the earlier of attainment of age 65 or he/she re-qualifies for Medicare.
- The Insurance Trust reserves the right to amend or terminate the Plan or change contributions at any time, for any reason, and without notice. There is neither vesting in benefits nor a vested right to benefits.
- be a Disability Retiree meeting the required specified conditions.

To be eligible to continue coverage, the Retiree must be receiving a monthly retirement benefit from TCRS and cannot be eligible for Medicare.

DEPENDENTS OF A DECEASED EMPLOYEE

Coverage for the Dependents of a deceased Employee will remain in force until the end of the month in which the Employee's death occurred. Coverage will then be available under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

EFFECTIVE DATE

The different types of coverage available to Employees are shown above.

If the Employee has met the eligibility requirements and the Employee and his or her Eligible Dependents apply when first eligible (or within 31 days), coverage will be effective on the next Effective Date BCBST bills the Employer. If the Employee and his or her Eligible Dependents do not apply when first eligible, the Employee will be subject to the requirements explained in "Late Enrollment" shown on a following page.

Employees and their Dependents will not be covered until their completed application for coverage, listing all eligible Dependents, has been received by BCBST and the Employee has been issued a membership ID card or has received other written notice that coverage is in effect.

APPLYING FOR COVERAGE

After meeting the eligibility requirements, an Employee may apply for one of the types of coverage shown above.

To be eligible to enroll as a Covered Dependent, a Member must be listed on the enrollment form completed by the Subscriber, meet all dependent eligibility criteria established by the Employer, and be:

- The Subscriber's current spouse as recognized by Tennessee law; or
- The natural, legally adopted, or step-child(ren) of the Subscriber or the Subscriber's spouse who is under the age limit stated on the Schedule of Benefits. In addition, eligible Dependents shall include children placed with the Subscriber or the Subscriber's spouse pending adoption and children for whom the Subscriber or Subscriber's spouse is court-appointed legal guardian; or
- A child of Subscriber or Subscriber's spouse for whom a Qualified Medical Child Support Order has been issued; or

- 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.

Employer agrees to defend or settle, and hold BCBST harmless from claims, losses, or suits relating to eligibility or insurability of any applicant, Subscriber, Employee or Dependent in administering this provision.

CHANGING COVERAGE

If the Subscriber's marital status changes (marriage or divorce) or if there is a change in the number of children (birth, adoption), the Subscriber may want to change coverage to one of the other options available.

To make a change, the Subscriber should (1) tell the employer, and (2) apply for any needed change within 31 days of the change in family status, date the new Dependent is acquired, etc.

A newborn child of the Subscriber or Subscriber's spouse is a Covered Dependent from the moment of birth. The Subscriber must enroll that child within 31 days of the date of birth. If the Subscriber fails to do so, and an additional Payment is required to cover that child, the Plan will not provide Coverage for that child after 31 days from the child's date of birth.

Changes in coverage will begin on the next Effective Date BCBST bills the employer for this coverage (normally the first day of the month). Coverage for new Dependents added begins on the date the Dependent is acquired if the application is received within 31 days after that date.

Late Enrollment

If Subscribers wait more than 31 days from the date they are first eligible to apply or add a

Dependent, they will be considered a Late Enrollee and will not be eligible for benefits in connection with a Pre-existing Condition until after the Pre-existing Condition Waiting Period has ended. Coverage for the Member will otherwise be effective on the next billing date following Our receipt of the application for Coverage.

However, a person will not be considered a Late Enrollee if:

- he or she already had other health care coverage at the time coverage under this plan was previously offered; and
- he or she stated in writing at that time that such other coverage was the reason for declining coverage under this plan; and
- such other coverage is exhausted (if the previous coverage was continuation coverage under COBRA) or the other coverage was terminated because he or she ceased to be eligible or employer contributions for such coverage ended; and
- he or she applies for coverage under this plan within 31 days after the loss of the other coverage.

Dependents who become eligible for coverage under this plan by reason of marriage, birth, adoption or placement for adoption after the Subscriber's Effective Date will not be considered Late Enrollees, provided application is made by the Subscriber on behalf of such person(s) within 31 days of the marriage, birth, adoption or placement for adoption.

REINSTATEMENT FOR MILITARY PERSONNEL RETURNING FROM ACTIVE SERVICE

An employee who returns to the Employer's active payroll following active military duty may reinstate insurance coverage on the earliest of the following:

- The first day of the month that includes the date on which the military person was discharged from active duty;
- The first of the month following the date of discharge from active duty;
- The date on which the military person returns to the employers active payroll;
- The first of the month following the military persons return to the employer's active payroll.

If coverage is reinstated before the employee returns to the Employer's active payroll, the employee must pay 100 percent of the total premium. In all instances, employees must pay whole month premiums.

Reinstatement of coverage is not automatic. Returning military personnel must reapply within 90 days from the end of their leave before coverage can be reinstated. No pre-existing condition provision or waiting period requirements will apply.

Enrollment upon Change in Status

An Employee may be eligible to change his or her Coverage other than during the Open Enrollment Period when he or she has a change in status event. The Employee must request the change within 31 days of the change in status. Any change in the Subscriber's elections must be consistent with the change in status.

To notify the Plan of a change in status event, the Subscriber must submit a change form to the Group representative within 31 days from the date of the event causing that change of status. Such events may include, but are not limited to: (1) marriage or divorce; (2) death of the Subscriber's spouse or dependent; (3) dependency status; (4) Medicare eligibility; (5) coverage by another Payor; (6) birth or adoption of a child; (7) termination of employment, or commencement of employment, of the Subscriber's spouse; (8) switching from part-time to full-time, or from full-time to part-time status by the Subscriber or the Subscriber's spouse; (9) the Subscriber or the Subscriber's spouse taking an unpaid leave of absence, or returning from unpaid leave of absence; (10) significant change in the health coverage of the Subscriber's or the Subscriber's spouse attributable to the spouse's employment.

SECTION II - BLUECARD/BLUECARD PPO PROGRAM

When You are in an area where Our 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/BlueCard PPO Participating Doctor and Hospital Information Line at 1-800-810-BLUE (2583.)

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

If You call 1-800-810-BLUE (2583), **and** go to a BlueCard/BlueCard PPO Participating Physician or Hospital, Your benefits will be Covered as In-network benefits, and Your out-of-pocket expenses will be less than if You go to a non- BlueCard/BlueCard PPO Participating Provider or Hospital.

In the BlueCard/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/BlueCard PPO Participating Provider. The BlueCard/BlueCard PPO Participating Provider can verify your membership, eligibility and Coverage with Your BlueCross BlueShield Plan. When You visit a BlueCard/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 Our service area that are processed through the BlueCard/BlueCard PPO Program will typically be at the lower of the provider's Billed Charges or the negotiated price We pay the Host Plan.

The negotiated price We pay to the Host Plan for health care services provided through the BlueCard/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 Host Plan's health care Providers or one or more particular Providers; or (c) a discount from Billed Charges representing the Host 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 US. IF PRIOR AUTHORIZATION IS NOT RECEIVED, YOUR BENEFITS MAY BE REDUCED OR DENIED. CALL THE 1-800 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.

**SECTION III -
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 counseling, low-risk case management, catastrophic medical and transplant case management and the development and publishing of medical policy.

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

A. Prior Authorization

BCBST must Authorize some Covered Services in advance in order for those Covered Services 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 a prescription drug card)
- Advanced Radiological Imaging services
- Durable Medical Equipment (DME) greater than \$500

- 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.

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

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

The Member is not held harmless if:

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

If 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 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 and Health Education --

Lifestyle and 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 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 special 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 the 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, it may be determined that alternative treatment is Medically Necessary and Appropriate.

In that event, alternative benefits for services not otherwise specified as Covered Services in Attachment A may be offered to the Member. Such benefits shall not exceed the Lifetime Maximum specified or the total amount of benefits under this EOC, and will be offered only in accordance with a written case management or alternative treatment plan agreed to by the Member's attending physician and BCBST.

Emerging Health Care Programs -- Care Management is continually evaluating emerging health care programs. These are services or technologies that demonstrate reasonable potential improvement in access, quality, health care costs, efficiency, and Member satisfaction. When We approve an emerging health care program, 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 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” means 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. BCBST’s Medical Policies are made a part of this EOC by reference.

Medical policies sometimes define certain terms. If the definition of a term defined in a medical policy differs from a definition in this EOC, the medical policy definition 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 the membership ID card. Your concern will be noted and investigated by Our Clinical Risk Management department.

SECTION IV - YOUR BENEFITS

Your Network coverage provides benefits for most medical services and supplies received by a covered Subscriber or Dependent. However, not all medical expenses are covered. It is important for You to understand which services are covered by this program.

Most health care coverage contains limitations and exclusions. Most of the limitations and exclusions that apply to this program are outlined in this EOC.

Benefits will be provided under Your coverage only for services or supplies that are Medically Necessary and performed and billed by an Eligible Provider. Services must be related to the diagnosis and/or treatment of a Member's illness, injury, or pregnancy. The portion of any charge for a service or supply that is more than the Maximum Allowable Charge amount will not be considered covered.

Your benefits for each expense will normally be a percentage of the Maximum Allowable Charge as stated in the Schedule of Benefits.

You should refer to the Schedule of Benefits to see what benefit maximums apply.

Obtaining services not listed in this Attachment or not in accordance with the administrator's medical policies and procedures may result in the denial of payment or a reduction in reimbursement for otherwise eligible Covered Services. The administrator's Medical Policies can help Your Provider determine if a proposed service will be Covered.

HOSPITAL AND OTHER FACILITY PROVIDER SERVICES

Inpatient Services

Room, board, and general nursing care in a

- semi-private room,
- private room (limited to most common semi-private room rate, unless approved by BCBST),
- Special Care Unit as approved by BCBST;
- Use of operating, delivery and treatment rooms;
- Drugs and medicines, including take home drugs;

- Sterile dressings, casts, splints and crutches;
- Anesthetics;
- Diagnostic services (x-ray and laboratory and certain other tests); and
- Certain therapy services.

Room, board and general nursing care will not be covered on the day of discharge unless admission and discharge occur on the same date, except this does not include a 23-hour observation room.

Outpatient Services

- Treatment of accidental injuries;
- Treatment of a sudden and serious illness;
- Removal of sutures, anesthetics and their administration, and other surgical services provided by a Hospital Employee other than the surgeon or assisting surgeon;
- Drugs, crutches, and medical supplies; and
- Pre-admission testing.

Emergency Services

Benefits will be provided as specified in the Schedule of Benefits for Emergency Services received in a Hospital Emergency department when symptoms have been recorded by the attending Physician that an Emergency Medical Condition could exist.

Prior Authorization for Emergency Services will not be required. However, once the Member's medical condition has stabilized, Prior Authorization will be required for continuing Inpatient care or transfer to another facility. Benefits will be reduced or denied if such Prior Authorization is not obtained.

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES

Surgery

Operative and cutting procedures.

Multiple or Bilateral Surgical Procedures

When two or more covered surgical procedures are performed at the same time, or in one surgical setting, benefits will be based on:

- the amount of benefits for the procedure for which the highest dollar amount would be billed (if charges for the surgical procedures are different); and

- up to one-half of the benefits that are available with respect to the other covered surgical procedure(s), whether performed through the same or separate incisions.

Anesthesia

Anesthesia administered by a Registered Nurse Anesthetist (RNA) or a Physician (MD other than the operating surgeon) provided the Surgery is covered.

Physicians' Services

- A second and/or third surgical opinion received before Surgery
- Services of an attending Physician for Inpatient or Outpatient services, or consultation services when requested by the attending Physician
- Services of a Physician for treatment by x-ray, radium, or other radioactive substances
- Counseling services of a Physician, Licensed Psychologist designated, by law, as a health service provider, or Licensed Independent Practitioner of Social Work including treatment for drug addiction or alcoholism

Diagnostic Services

When ordered by a covered Provider to determine a specific condition or disease:

- diagnostic services, including X-ray and other radiology services;
- laboratory and pathology services;
- cardiographic, encephalographic, and radioisotope test;
- prostate specific antigen (PSA) test;
- transrectal ultrasound for prostate cancer;
- group B Streptococcus testing on pregnant or newborn Members as recommended by the American College of Obstetricians and Gynecologists and the Center for Disease Control; and
- one annual cervical cancer screening.

Maternity Services

Pregnancy and childbirth are covered on the same basis as an illness. Unless the mother and attending health care provider agree on an earlier date of discharge, benefits will be available for Hospital stays of not less than

48 hours following a conventional delivery or 96 hours following a cesarean delivery.

OTHER SERVICES

Ambulance

Benefits are available for an Ambulance to transport the Member:

- a. from a Member's home or the scene of an accident or medical Emergency to the nearest Hospital where appropriate medical or surgical services are available;
- b. between Hospitals; and
- c. between a Hospital and a Skilled Nursing Facility.

Benefits are available for air and water Ambulance only when ground Ambulance is not available or when justified by the patient's medical condition, as determined by BCBST.

Benefits are available for ground transportation providing intensive care for Members less than two years of age ("angel vans").

Cardiac Rehabilitation Services

Subject to Pre-Treatment Certification Requirements, benefits will be available as stated in the Schedule of Benefits for Cardiac Rehabilitation Services, including:

- cardiac exercise stress testing to obtain an exercise prescription;
- supervised exercise designed primarily to improve functional capacity (three visits per week for up to twelve weeks); or
- continuous ECG monitoring during exercise (for Members with high risk of recurrent cardiac events during exercise).

Services must begin within eight weeks following discharge from a Hospital following the Member's confinement for:

- myocardial infarction;
- coronary artery bypass surgery;
- Percutaneous transluminal coronary angioplasty;
- organ transplant (heart or heart/lung) surgery; or
- aortic or mitral valve surgery.

Services must be rendered in a Cardiac Rehabilitation Center (recognized by the American Association of Cardiovascular and Pulmonary Rehabilitation) in accordance with BCBST Medical Necessity guidelines

with regard to frequency and duration of exercise and education program.

Dental Care

Benefits are provided only for removal of impacted teeth or for dental work needed as a result of an Accidental Injury to the jaw, natural teeth, mouth, or face.

An injury caused by chewing or biting, or received in the course of other dental procedures, will not be considered an Accidental Injury.

Anesthesia for Dental Services

Benefits will be available for anesthesia, as well as Inpatient or Outpatient Hospital expenses, in connection with a dental procedure if such procedure involves:

- complex oral surgical procedures that have a high probability of complications due to the nature of the Surgery;
- concomitant systemic disease for which the patient is under current medical management and that increases the probability of complications;
- mental illness or behavioral condition that precludes dental Surgery in an office setting;
- use of general anesthesia, and the Member's medical condition requires such procedure be performed in a Hospital; or
- dental Surgery performed on a Member eight years of age or younger, where such procedure cannot safely be provided in a dental office setting.

Diabetes Treatment

Benefits are available for treatment, medical equipment, supplies and Outpatient self-management training and education, including nutritional counseling, for the treatment of diabetes. In order to be covered, such services must be:

- prescribed and certified by a Physician as Medically Necessary; and
- provided by a Network Physician, Registered Nurse, Dietitian, or Pharmacist who has completed a diabetes patient management program recognized by the American Council on Pharmaceutical Education and the Tennessee Board of Pharmacy.

Services and supplies included under this provision shall include:

- blood glucose monitors, including monitors for the legally blind;
- test strips for blood glucose monitors;
- visual reading and urine test strips;
- injection aids;
- syringes and lancets;
- insulin pumps, infusion devices, and Medically Necessary accessories;
- podiatric appliances for prevention of complications associated with diabetes; and
- glucagon Emergency kits.

(Benefits for insulin and oral hypoglycemic agents will also be available).

Durable Medical Equipment and Supplies

Benefits are available for the rental and, where deemed appropriate by BCBST, the purchase of Durable Medical Equipment when Medically Necessary and prescribed by a Physician.

Benefits are also available to fit, adjust, repair, or replace Durable Medical Equipment, provided the need for this arises from normal wear or the Member's physical development -- and not as a result of improved technology or loss, theft, or damage.

Benefits are available for cranial hair prostheses (wigs) for hair loss resulting from chemotherapy, radiation, autoimmune and other clinical disease, subject to Deductible and Coinsurance and a \$500 Lifetime Maximum.

When Durable Medical Equipment is rented and the rental will extend beyond the period for which it was originally prescribed, a Physician must re-certify that the equipment is Medically Necessary for continued treatment. If a request for re-certification is not submitted, benefits will cease on the date through which use of the equipment was previously prescribed.

Eyeglasses or Contact Lenses

- one set following cataract Surgery

Home Health Care

Benefits are available for the following services when prescribed by Your Physician and performed and billed by a Home Health Care Agency: part-time or intermittent nursing care by a visiting RN or LPN (not to include private duty nursing); physical therapy and respiratory therapy by persons

licensed to perform such services; oxygen and its administration; and diagnostic services.

Hospice Home Care

(Benefits are provided at 100%)

- Hospice Home Care is an alternative to lengthy Inpatient treatment for terminally ill patients
- the patient's Physician must establish a plan of treatment
- an Approved Hospice must provide the services.

In-home services are available, such as:

- prescription drugs;
- medical supplies;
- Durable Medical Equipment;
- and other essential medical services.

Office Visits for an Illness or Injury

Benefits will be available for an office visit in connection with an annual cervical cancer screening.

Organ Transplants

As soon as Your Provider tells You that You might need a transplant, You or Your Provider needs to contact Transplant Case Management.

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: In-Transplant Network, In-Network, and Out-of-Network. If You go to an In-Transplant Network Provider, You will have the highest level of benefits.

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 BCBST 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 Transplant Case Management before pre-transplant evaluation or Transplant Services are received. Approval 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 ID card for customer service, and ask to be transferred to Transplant Case Management. BCBST 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. The 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.

- (1) 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 Transplant Network.
 - (2) Meals and lodging expenses, limited to \$150 daily.
 - (3) The aggregate limit for travel expenses is \$10,000 per Covered Procedure and is included in Your Lifetime Benefit Maximum.
 - (4) Travel Expenses are Covered only if You go to a Contracted Transplant 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 Physician 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 BCBST in coordination of these services;

- c. Failure to notify BCBST of proposed transplant services, or to coordinate all transplant related services with BCBST, 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 the Schedule of Benefits, at the Transplant Maximum Allowable Charge. The In-Transplant Network Provider cannot 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 levels listed in the 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 the 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 the 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;

If You go through Transplant Case Management for Your transplant, follow its procedures, cooperate fully with them, and have Your transplant performed at a Contracted Transplant Institution, the transplant expenses specified in the Schedule of Benefits are Covered.

4. Exclusions

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

- a. If You do not receive Prior Authorization, the transplant and related services will not be Covered;
- b. Any service specifically excluded from Coverage, 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 are covered under 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 within 3 months of harvest;
- 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.

Outpatient Private Duty Nursing

Benefits are available for private duty nursing when such care is given by a practicing Registered Nurse (RN) or a Licensed Practical Nurse (LPN), provided their professional skills are Medically Necessary to provide the appropriate level of care; and such services are ordered by a Physician.

Preventive/Well Care Services

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 section.
- 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 the Schedule of Benefits.

Prosthetic Appliances

Benefits are available for orthopedic braces (except corrective shoes and arch supports), crutches, and prosthetic appliances such as artificial limbs and eyes. Replacement, repair, or adjustment of the appliances is also covered if the need for this arises from normal wear or the Member's physical development and not as a result of improved technology, loss, theft, or damage to the appliance or device.

Therapy Services

- **aquatic therapy** – physical therapy performed in water
- **chemotherapy** --treatment of malignant disease by chemical or biological agents
- **dialysis** -- treatment of a kidney ailment, including the use of an artificial kidney machine
- **Home Infusion Therapy** -- treatment that involves the continuous slow introduction of a solution into the body
- **Inpatient rehabilitation services** – a confinement primarily for rehabilitative services (these services are limited to 100 days per Calendar Year)

- **occupational therapy** -- treatment that involves the use of activities designed to restore, develop and/or maintain a person's ability to accomplish those daily living tasks necessary to a particular occupational role
- **physical therapy** -- treatment to relieve pain, restore bodily function, and prevent disability following illness, injury, or loss of a body part
- **radiation therapy** -- treatment of disease by x-ray, radium, or radioactive isotopes
- **respiratory therapy** -- introduction of dry or moist gases into the lungs
- **speech therapy** -- treatment to restore or significantly improve a speech loss or impairment due to a congenital defect for which corrective Surgery has been performed, Accidental Injury, or disease other than a functional nervous disorder.

SECTION V - LIMITATIONS/EXCLUSIONS

The services and supplies described in this EOC are subject to Medical Necessity, coverage provisions and the following limitations and exclusions. When a service or supply is limited or excluded all expenses related to and in connection with the service and/or supply will also be limited or excluded. Read this section carefully before submitting a claim.

PRE-EXISTING CONDITIONS LIMITATIONS

A Pre-existing Condition is a physical or mental condition (except for pregnancy), or any other condition that was present during the six months period before the Member's Enrollment Date under the Plan, for which medical advice, diagnosis, care or treatment was recommended or received from a Provider of health care services.

No benefits will be paid for a Pre-existing Condition until 12 months from the Enrollment Date. This Pre-existing Waiting Period may be reduced by periods of Creditable Coverage provided there is no more than a 63 day break in coverage. Waiting periods required before coverage becomes effective will not count toward the 63 day break in coverage.

EXCLUSIONS

1. services or supplies not prescribed or performed by a Physician or Professional Other Provider, as defined in the Basic Terms Section
2. services or supplies that are not Medically Necessary
3. services provided before the Member's coverage begins or during the Pre-Existing Waiting Period specified in the Schedule of Benefits
4. a drug, device, or medical treatment or procedure that is experimental or Investigational (see Section XII, Definition of Terms)
5. any work related illness or injury compensable under Workers' Compensation or On the Job Injury Program.

6. services or supplies furnished without cost under the laws of any government except Medicaid (TennCareSM) coverage provided by the State of Tennessee
7. illness or injury resulting from war occurring after the Member's coverage begins
8. services for which the patient is not required or legally obligated to pay
9. services or supplies received in a dental or medical department maintained by or on behalf of an Employer, mutual benefit association, labor union, trust, or similar group
10. services, supplies or prosthetics primarily to improve appearance or that are provided in order to correct or repair the results of a prior surgical procedure the primary purpose of which was to improve appearance

However, reconstructive breast Surgery as a result of a mastectomy (other than a lumpectomy), and Surgery on the non-diseased breast needed to establish symmetry between the two breasts is covered.

Benefits will also be available for surgery needed to restore an impaired bodily function if the condition results from:

- disease;
 - birth defect;
 - Surgery (excluding non-functional scar revision); or
 - Accidental Injury.
11. self-treatment or services provided by any person related to the Member by blood or marriage, including the Member's spouse, parent, child, legal guardian, aunt, uncle, stepchild, or any person who resides in the Member's immediate household
 12. services rendered by other than a Hospital, Physician or Other Provider(s) specified in this Plan
 13. services paid under any other group, blanket or franchise insurance coverage; any other BlueCross or BlueShield group health plan, other health insurance plan, union welfare plan, or labor-management trust plan

14. personal hygiene and convenience items (such as air conditioners, humidifiers, or physical fitness equipment)
15. telephone consultations, charges incurred due to failure to keep a scheduled appointment, or charges to complete a claim form or to provide medical records
16. Hospital admissions that are primarily for diagnostic studies
17. whole blood, blood components, and blood derivatives that are not officially classified as drugs
18. Custodial Care
19. routine foot care, or the treatment of flat feet, corns, bunions, calluses, toe nails, fallen arches, weak feet, and chronic footstrain
20. routine physical examinations, immunizations, and screening examinations including x-rays made without film, except as otherwise specified
21. Physician's charges for well-baby care, except as otherwise specified
22. services or supplies for dental care (except as specified in Section IV – Your Benefits) including, but not limited to: (1) crowns; (2) caps; (3) plates; (4) bridges; (5) dental x-rays; (6) fillings; (7) periodontal surgery; (8) prophylactic removal of non-impacted wisdom teeth; (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.
23. eyeglasses, contact lenses, and examinations for and the fitting of eyeglasses and contact lenses
24. hearing aids and examinations for and the fitting of hearing aids;

Hearing aids shall include a conventional device to restore or enhance the patient's ability to hear. However, benefits for certain surgical procedures to restore hearing may be available if approved as Medically Necessary.
25. Hospital admissions primarily for physical therapy

(Physical therapy is covered where there is another primary diagnosis.)
26. rehabilitative services of any kind, including, but not limited to, hydrotherapy and educational therapy, except as otherwise specified

(If we determine that services during a continuous Hospital confinement have developed into primarily rehabilitative services, that portion of the stay beginning on the day of such development will be covered, subject to the Deductible and Coinsurance, but limited to 100 days per Calendar Year.)
27. Surgery to change sex, and related services
28. procedures, drugs or biologicals for, or in connection with, artificial insemination, in vitro fertilization, or any other service or supply intended to create a pregnancy

However, a service or supply may be covered if it is provided to treat an illness or underlying medical condition resulting in infertility. Services that may be covered under this provision include:

 - treatment to correct a previous tubal pregnancy, and
 - treatment by ovulatory drugs (such as clomid) or hormonal treatment used primarily to treat irregular menstrual periods.
29. services covered under Medicare, except as required by applicable state or federal law
30. non-medical self-care or self-help training and any related diagnostic testing or medical social services
31. any services or supplies designed to correct refractive errors of the eyes, except Surgery for removal of cataracts (including surgical implant of a prosthetic lens following cataract extraction), except as otherwise specified
32. an artificial heart or any other artificial organ, or any associated expense

33. services or supplies for the reversal of sterilization
34. services or supplies incurred after a Concurrent Review determines the services and supplies are no longer Medically Necessary
35. charges in excess of the Maximum Allowable Charge for Covered Services
36. services rendered for or in connection with physical therapy that consist primarily in the application, supervision, or direction in the use of exercise or physical fitness equipment--whether or not such services are rendered by an Eligible Provider
37. any balance of charges, Deductibles, or Coinsurance resulting from a Member's failure to comply with applicable requirements of any other individual or group health plan, including: Prior Authorization, second surgical opinion consultation, Outpatient Surgery, or concurrent care review programs
38. services or supplies in connection with treatment of obesity, except as otherwise noted
39. any charges for services and supplies rendered to a Member that require the Prior Authorization of BlueCross BlueShield of Tennessee, where such Prior Authorization is not given
40. services required as a result of the commission of a felony by the Member, or the attempt to commit a felony
41. services or supplies rendered prior to the Effective Date or after a Member's coverage is terminated, except as otherwise specified
42. room, board, and general nursing care rendered on the date of discharge, unless both admission and discharge occur on the same day
43. a second or third surgical opinion rendered by a Physician in the same medical group or practice as (a) the Physician who initially recommended the Surgery, or (b) the Physician who rendered either the second or third surgical opinion
44. staff consultations required by Hospital rules
45. prosthetic appliances or items of Durable Medical Equipment to replace those that were lost, damaged, or stolen or prescribed as a result of improved technology
46. exercise or athletic equipment, saunas, whirlpools, air conditioners, water purifiers, humidifiers, home modifications or improvements, motorized vehicles (except electric wheelchairs), swimming pools, tanning beds, and recreational equipment
47. dental appliances, including those used for correction of jaw malformations, except where prescribed as part of a surgical procedure necessary to restore a major bodily function
48. Inpatient private duty nursing in an acute care Hospital
49. over-the-counter drugs (not requiring a prescription), unless required by law or specifically designated as covered under this Plan; prescription devices, vitamins, except those that by law require a prescription; and/or prescription drugs dispensed in a doctor's office
50. for any care or treatment involving acupuncture
51. replacement of implanted cataract lenses
52. for court-ordered treatment of a Subscriber unless benefits are otherwise payable
53. medical treatment for which the Member has been reimbursed under a mass tort or class action lawsuit, settlement or judgment
54. abortion, unless the life of the mother is in danger

SECTION VI - CLAIMS AND PAYMENT

When You receive Covered Services, either You or the Provider must submit a claim form to Us. We will review the claim, and let You, or the Provider, know if We need more information, before We pay or deny the claim. We follow Our internal administration procedures when We adjudicate claims.

CLAIMS

Due to federal regulation, there are several terms to describe a claim: pre-service claim; post-service claim; and a claim for Urgent Care.

- a. 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.
- b. 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.
- c. 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.

CLAIMS BILLING

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.

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.

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 as described in sections a. and b. above. 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).

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.

A Network Provider or an Out-of-Network Provider may refuse to render, 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.
- c. 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.

PAYMENT

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

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. 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.

- a. Non-Contracted Providers may or may not file Your claims for You. Either way, the In-Network Benefit level shown in the Schedule of Benefits, 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.

- b. If the ASA 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 were received.
- c. 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. We are not responsible for over or under payment of claims if Our information is not complete or inaccurate. We will make reasonable efforts to obtain and verify relevant facts when claim forms are submitted.
- d. When a claim is paid or denied, in whole or part, You will receive 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 administrator will send the EOB to the last address on file for You.
- e. 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 the Schedule of Benefits.

"INFORMATION PLEASE.."

Whenever You need to file a claim, 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 the customer service number shown on the 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

In addition to using a claim form, there are two other ways You can help to ensure timely response to Your claim:

1. Keep Us informed if You have other health insurance.

In processing a claim where two or more group health programs are involved, benefits are coordinated between the two programs. This coordination allows the patient, whenever possible, to meet his health care expenses -- and yet not collect more than the actual costs.

To avoid delays that may occur when We have to ask about Your coverage under another plan, be sure to let Us know if You become covered under another group health program.

2. Let Us know if You move.

Notify Us of Your new address to make sure You receive claim payments and Explanations of Benefits (EOB) paid on Your behalf. Change of address cards are available through the company's Benefits Manager.

**SECTION VII -
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." 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 be increased because of this provision.

If this COB provision applies, the order of benefits determination rules should be looked at first. Those rules determine whether the Plan's benefits 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 coverages;

- (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 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 TennCaresm);
 - (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 employee welfare benefit plan 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 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 a service is deemed to be 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 a Calendar Year. 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 has covered one parent longer are determined before those of the Plan that has 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 in Paragraph 2(b), 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 are determined before those of a Plan that covers that person as a laid off or retired

Employee. 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.

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 24 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.

If the Other Plan does not contain provisions establishing the Order of Benefit Determination Rules, the benefits under the Other Plan will be determined first.

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."

Rules. 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 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 proportionately and is then charged against any applicable benefit limit of This Plan.
- c. The administrator will not, however, consider the benefits of the Other Plan(s) in determining benefits under This Plan when:
 - (1) the Other Plan has a rule coordinating its benefits with those of This Plan and such rule states that benefits of the Other

Plan will be determined after those of This Plan; and

- (2) the order of benefit determination rules requires Us to determine benefits before those of the Other 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:

- a. The persons it has paid or for whom it has paid;
- b. Insurance companies; or
- c. 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 the Employer has 20 or fewer employees, the MSP rules might not apply. Please contact customer service at the toll free number on the Subscriber’s membership ID card if You have any questions.

SECTION VIII - GRIEVANCE PROCEDURES

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. Please contact the customer service department at the number listed on the 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.

- a. This Procedure is the exclusive method of resolving any Dispute. Exemplary or punitive damages are not available in any Grievance or litigation, pursuant to the terms of this EOC. Any decision to award damages must be based upon the terms of this EOC.
- b. The Procedure can only resolve Disputes that are subject to Our control.
- c. 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.
- d. This Procedure incorporates the definitions of: (1) Adverse Benefit Determination; (2) urgent care; and (3) pre-service and post-service claims (“Claims”), that are in the Employee Retirement Income

Security Act of 1974 (“ERISA”); Rules and Regulations for Administration and Enforcement; Claims Procedure (the “Claims Regulation”).

An Adverse Benefit Determination is any denial, reduction, termination or failure to provide or make payment for what You believe should be a Covered Service.

- 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 Us 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 Us 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 Our 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 a final Adverse Benefit Determination has been rendered in a matter being appealed through the Provider dispute resolution procedure.
- d. You may request a form from the Plan to authorize another person to act on Your behalf concerning a Dispute.
- e. We, the Plan and You may agree to skip one or more of the steps of this Procedure if it will not help to resolve the Dispute.

- f. Any Dispute will be resolved in accordance with applicable Tennessee or Federal laws and regulations, the ASA 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 the customer service department 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. First Level 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.

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. BCBST is a limited fiduciary for the first level Grievance.

1. Grievance Process

After We have 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, We 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. Such determinations shall be subject to the review standards applicable to ERISA plans, even if the Plan 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. You may receive a copy of such documentation or

information, without charge, upon written request.

C. Second Level Grievance

You may file a written request for reconsideration with Us within ninety (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 the Plan 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, the Plan agrees 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 Process

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 and You will be permitted to question each other and any witnesses during the hearing. You will also be permitted to make a closing statement to the committee at the end of the hearing.

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

If Your Grievance involves a Medical Necessity determination, then either: (1) after completion of the mandatory first level Grievance; or (2) after completion of the mandatory first level Grievance followed by completion of

the second level Grievance, You may request that the Dispute be submitted to a neutral third party, selected by Us, 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 oral testimony during the Grievance Process. Your request for independent review must be submitted in writing within 180 days after the date You receive notice of the decision. Receipt shall be deemed to have occurred no more than two days after the date of issuance of the 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 Employer or Employer's Plan, until the independent reviewer makes its decision.

The Employer or Employer's 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.

We will submit the necessary information to the independent review entity within 5 business days after receiving Your request for review. We 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 Us and We will submit the determination to 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 Us or You.

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

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

**SECTION IX -
SUBROGATION AND RIGHT OF
REIMBURSEMENT**

A. Subrogation Rights

The Plan assumes and is subrogated to Your legal rights to recover any payments the Plan makes for Covered Services, when Your illness or injury resulted from the action or fault of a third party. The Plan's subrogation rights include the right to recover the reasonable value of prepaid services rendered by Network Providers.

The Plan has the right to recover any and all amounts equal to the Plan's payments from:

- the insurance of the injured party;
- the person, company (or combination thereof) that caused the illness or injury, or their insurance company; or
- any other source, including uninsured motorist coverage, medical payment coverage, or similar medical reimbursement policies.

This right of recovery under this provision will apply whether recovery was obtained by suit, settlement, mediation, arbitration, or otherwise. The Plan's recovery will not be reduced by Your negligence, nor by attorney fees and costs You incur.

B. Priority Right of Reimbursement

Separate and apart from the Plan's right of subrogation, the Plan shall have first lien and right to reimbursement. The Plan's first lien supercedes any right that You may have to be "made whole". In other words, the Plan is entitled to the right of first reimbursement out of any recovery You might procure regardless of whether You have received compensation for any of Your damages or expenses, including Your attorneys' fees or costs. This priority right of reimbursement supersedes Your right to be made whole from any recovery, whether full or partial. In addition, You agree to do nothing to prejudice or oppose the Plan's right to subrogation and reimbursement and You acknowledge that the Plan precludes

operation of the "made-whole", "attorney-fund", and "common-fund" doctrines. You agree to reimburse the Plan 100% first for any and all benefits provided through the Plan, and for any costs of recovering such amounts from those third parties from any and all amounts recovered through:

- Any settlement, mediation, arbitration, judgment, suit, or otherwise, or settlement from Your own insurance and/or from the third party (or their insurance);
- Any auto or recreational vehicle insurance coverage or benefits including, but not limited to, uninsured motorist coverage;
- Business and homeowner medical liability insurance coverage or payments.

The Plan may notify those parties of its lien and right to reimbursement without notice to or consent from those Members.

This priority right of reimbursement applies regardless of whether such payments are designated as payment for (but not limited to) pain and suffering, medical benefits, and/or other specified damages. It also applies regardless of whether the Member is a minor.

This priority right of reimbursement will not be reduced by attorney fees and costs You incur.

The Plan may enforce its rights of subrogation and recovery against, without limitation, any tortfeasors, 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.

Notice and Cooperation

Members are required to notify the administrator promptly if they are involved in an incident that gives rise to such subrogation rights and/or priority right of reimbursement, to enable the administrator to protect the Plan's rights under this section. Members are also required to cooperate with the administrator and to execute any documents that the administrator, acting on behalf of the Employer, deems

necessary to protect the Plan's rights under this section.

The Member shall not do anything to hinder, delay, impede or jeopardize the Plan's subrogation rights and/or priority right of reimbursement. Failure to cooperate or to comply with this provision shall entitle the Plan to withhold any and all benefits due the Member under the Plan. This is in addition to any and all other rights that the Plan has pursuant to the provisions of the Plan's subrogation rights and/or priority right of reimbursement.

If the Plan has to file suit, or otherwise litigate to enforce its subrogation rights and/or priority right of reimbursement, You are responsible for paying any and all costs, including attorneys' fees, the Plan incurs in addition to the amounts recovered through the subrogation rights and/or priority right of reimbursement.

Legal Action and Costs

If You settle any claim or action against any third party, You shall be deemed to have been made whole by the settlement and the Plan shall be entitled to collect the present value of its rights as the first priority claim from the settlement fund immediately. You shall hold any such proceeds of settlement or judgment in trust for the benefit of the Plan. The Plan shall also be entitled to recover reasonable attorneys' fees incurred in collecting proceeds held by You in such circumstances.

Additionally, the Plan has the right to sue on Your behalf, against any person or entity considered responsible for any condition resulting in medical expenses, to recover benefits paid or to be paid by the Plan.

Settlement or Other Compromise

You must notify the administrator prior to settlement, resolution, court approval, or anything that may hinder, delay, impede or jeopardize the Plan's rights so that the Plan may be present and protect its subrogation rights and/or priority right of reimbursement.

The Plan's subrogation rights and priority right of reimbursement attach to any funds held, and do not create personal liability against You.

The right of subrogation and the right of reimbursement are based on the Plan language in effect at the time of judgment, payment or settlement.

The Plan, or its representative, may enforce the subrogation and priority right of reimbursement.

**SECTION X -
TERMINATION OF MEMBER
COVERAGE**

1. Termination or Modification of Coverage by BCBST or the Employer

BCBST or the Employer may modify or terminate the ASA. Notice to the Employer of the termination or modification of the ASA is deemed to be notice to all Members Covered under the Plan. The Employer is responsible for notifying You of such a termination or modification of Your Coverage.

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

2. Termination of Coverage Due to Loss of Eligibility

Your Coverage will terminate if You do not continue to meet the eligibility requirements agreed to by the Employer and the administrator during the term of the ASA. Coverage for a Member who has lost his or her eligibility shall automatically terminate at 12:00 midnight on the day that loss of eligibility occurred.

3. Termination of Coverage for Cause

The Plan may terminate Your Coverage for cause, if:

- a. You fail to make a required Member payment when it is due. (The fact that You have made a Payment contribution to the Employer will not prevent the administrator from terminating Your Coverage if the Employer fails to submit the full Payment for Your Coverage to the administrator when due); or
- b. You act in such a disruptive manner as to prevent or adversely affect the ordinary operations of the Plan; or

- c. You fail to cooperate with the Plan or Employer as required; or
- d. 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.

4. Right to Request a Hearing

You may appeal the termination of Your Coverage 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.

5. 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 its attorneys' fees.

When the ASA terminates, all benefits for Covered Services terminate on that date.

SECTION XI - CONTINUATION OF COVERAGE

Federal Law

If the ASA remains in effect, but Your Coverage under this EOC would otherwise terminate, the Employer may offer You the right to continue Coverage. This right is referred to as “COBRA 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 may be eligible for COBRA Continuation Coverage. The following are qualifying events for such Coverage:

a. Subscribers. Loss of Coverage because of:

- The termination of employment except for gross misconduct.
- A reduction in the number of hours worked by the Subscriber.

b. Covered Dependents. Loss of Coverage because of:

- The termination of the Subscriber’s Coverage as explained in subsection (a), above.
- The death of the Subscriber.
- Divorce or legal separation from the Subscriber.
- The Subscriber becomes entitled to Medicare.
- A Covered Dependent reaches the limiting age.

c. Enrolling for COBRA Continuation Coverage

The administrator, acting on behalf of the Employer, shall notify You of Your rights to enroll for COBRA Continuation Coverage after:

- The Subscriber’s termination of employment, reduction in hours worked, death or entitlement to Medicare coverage; or

- The Subscriber or Covered Dependent notifies the Employer, 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 the right to COBRA Continuation Coverage to enroll for such Coverage. The Employer or the administrator will send the forms that should be used to enroll for COBRA Continuation Coverage. If You do not send the Enrollment Form to the Employer 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 submitting the Payment 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 submit the Payment for Coverage, and submit a claim for those Covered Services as set forth in the Claim Procedure section of this EOC.

d. Payment

You must submit any Payment required for COBRA Continuation Coverage to the administrator at the address indicated on Your Payment notice. If You do not enroll when first becoming eligible, the Payment 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 Employer (or to the administrator, if so directed by the Employer) within 45 days after the date You enroll for COBRA Continuation Coverage. After enrolling for COBRA Continuation Coverage, all Payments are due and payable on a monthly basis as required by the Employer. If the Payment is not received by the administrator on or before the due date, Coverage will be terminated, for cause, effective as of the last day for which Payment was received as explained in the Termination of

Coverage Section. The administrator may use a third party vendor to collect the COBRA Payment.

e. Coverage Provided

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

f. Duration of Eligibility for COBRA Continuation Coverage

COBRA Continuation Coverage is available for a maximum of:

- 18 months if the loss of Coverage is caused by termination of employment or reduction in hours of employment; or
- 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 or any other non-disabled qualified beneficiary affected by the termination of employment qualifying event must.
 - 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

- 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
- 36 months of Coverage if the loss of Coverage is caused by:
 - the death of the Subscriber;
 - loss of dependent child status under the Plan;
 - the Subscriber becomes entitled to Medicare; or
 - divorce or legal separation from the Subscriber; or
- 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.

g. Termination of COBRA Continuation Coverage

After You have elected COBRA Continuation Coverage, that 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:

- The Payment for such Coverage is not submitted when due; or
- You become Covered as either a Subscriber or dependent by another group health care plan, and that coverage is as good as or better than the COBRA Continuation Coverage; or
- The ASA is terminated; or
- You become entitled to Medicare Coverage; or

- The date that You, otherwise eligible for 29 months of COBRA Continuation Coverage, are determined to no longer be disabled for purposes of the COBRA law.

h. 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.

i. 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.

j. Continued Coverage During Other Leaves of Absence

The Employer may allow Subscribers to continue their Coverage during other leaves of absence. Please check with the Employer to find out how long Subscribers may take a leave of absence.

Subscribers also have to meet these criteria to have continuous Coverage during a leave of absence:

1. The 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.

A Subscriber may apply for COBRA Continuation if the leave lasts longer than allowed by the Employer.

k. The Trade Adjustment Assistance Reform Act of 2002

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 the Employer or the Department of Labor.

SECTION XII - DEFINITION OF TERMS

Accidental Injury - means a traumatic bodily injury that, if not immediately diagnosed and treated, could reasonably be expected to result in serious physical impairment or loss.

Actively At Work – The performance of all of an Employee’s regular duties for the Employer on a regularly scheduled workday at the location where such duties are normally performed. Eligible Employees will be considered to be Actively At Work on a non-scheduled work day (which would include a scheduled vacation day) only if the Employee was Actively At Work on the last regularly scheduled work day. An eligible Employee who is not at work due to a health-related factor shall be treated as Actively At Work for purposes of determining Eligibility.

Administrative Services Agreement (ASA) - means the agreement between BCBST and the Employer. It includes the ASA and any attached papers or riders (including the Letter of Intent, if any).

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

Allied Health Professional - is a health care provider, other than a Physician, who has entered into a contract with BCBST to provide Covered Services to a Member under this plan.

Ambulance - a specially designed and equipped vehicle used only to transport the sick and injured.

Ambulatory Surgical Facility - a health care facility that provides surgical services but usually does not have overnight accommodations; has an organized staff of Physicians and permanent facilities and equipment; and is not used primarily as an office or clinic for a Physician or other professional private practice.

Such a facility must be licensed as an Ambulatory Surgical Facility by the state in which it is located or must be operated by a Hospital licensed by the state in which it is located.

Authorized Service - is any Covered Service that has been authorized by the Medical Director.

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.

Billed Charges - means 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.

BlueCard PPO Participating Provider – A physician, Hospital, licensed skilled nursing facility, home health care provider or other Provider who contracts with other BlueCross and/or BlueShield Association, (BlueCard PPO) Plans and/or whom the Plan has Authorized to provide Covered Services to Members.

BlueCard Program - a program established by BlueCross and/or BlueShield organizations and the BlueCross BlueShield Association to process and pay claims for Covered Services received by a Member of a BlueCross and/or BlueShield organization from a provider outside the organization’s Service Area with whom that organization does not have an agreement.

Calendar Year – The period of time beginning at 12:01 A.M. on January 1st and ending 12:00 A.M. on December 31st.

Care Management - is a process directed at linking individual Members and families with the appropriate medical services and community resources necessary to manage the Member’s total care to promote optimum quality and optimum outcomes. Care Management involves a systematic process of assessing, planning, service coordination and monitoring through which multiple health needs of patients are met.

Coinsurance - the amount stated as a percentage of the Maximum Allowable Charge for a Covered Service that is the responsibility of the Member during the Calendar Year after any Deductible has been satisfied.

The Member will be responsible for the difference between Billed Charges and the Maximum Allowable Charge for a Covered Service if an Out-of-Network Provider’s Billed Charges are more than the Maximum Allowable Charge for Services. In such

case, the Member's total payment as a percentage of the Out-of-Network Provider's Billed Charges may exceed the Coinsurance Payment percentage set forth in the Schedule of Benefits.

Concurrent Review - refers to the determination under BCBST's Utilization Management Program of whether continued Inpatient or Outpatient care, or a given level of service, is Medically Necessary.

This review can be performed by the Provider's Utilization Management staff, Our Review Coordinator, or other person(s) designated by BCBST's Medical Director.

If, under such review, it is determined that continued care is not Medically Necessary, the facility and Physician will be notified in writing of a specific date after which benefits will no longer be payable under this plan. The Member or Physician can appeal the decision by contacting us. The case will be reviewed and both the Physician and the Member will be notified of the results.

Copayment - means the dollar amount (as specified in the Schedule of Benefits) for which a Member is responsible when a particular service or supply is received.

Copayments do not apply toward satisfying Deductibles, Out-of-Pocket, or lifetime maximums.

Cosmetic Surgery – Any treatment intended to improve Your appearance. Our Medical Policy establishes the criteria for what is cosmetic, and what is Medically Necessary and Appropriate.

Covered Charge - amount of total charge that is eligible for consideration of payment.

Covered Service - is a Medically Necessary service or supply (specified in this plan) for which benefits may be available.

Creditable Coverage - individual or group health coverage of the Member prior to his or her Enrollment Date that may be applied to reduce a Member's Pre-existing Condition Waiting Period, if any, stated in this plan. Creditable Coverage also includes coverage under COBRA, a health maintenance organization, Medicare, Medicaid (including TennCareSM), the Federal Employee Health Benefit Plan, and/or a public, government, military or Indian Health Service benefit program, and/or State Children's Health Insurance Program (S-CHIP).

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

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.

Deductible - the dollar amount of Covered Services specified in the Schedule of Benefits that must be incurred and paid by a Member before benefits are payable for all or part of the remaining Covered Services. Neither Copayments nor any balance of charges (between Billed Charges and the Maximum Allowable Charge) required for services will be considered when determining if the Member has satisfied a Deductible.

The Deductible will apply to the Out-of-Pocket and Family Out-of-Pocket Maximums.

Dependent - spouse (under a legally existing marriage between persons of the opposite sex) and children who are less than 26 years old including adopted children and stepchildren.

Drug Formulary - is a list of prescription medications that designates products that are approved for coverage by BCBST and that will be dispensed through participating pharmacies to Members. This list is subject to periodic review and modification by BCBST.

Durable Medical Equipment - equipment that:

- can only be used to serve the medical purpose for which it is prescribed;
- is not useful to the patient or other person in the absence of illness, injury or disability;
- is able to withstand repeated use; and
- is appropriate for use within the home.

Such equipment will not be considered a Covered Service, even if it is prescribed by a Physician or Other Provider, simply because its use has an incidental health benefit.

Effective Date - is the date on which coverage of a Member begins under this plan according to the Schedule of Eligibility.

Eligibility Waiting Period - the period that must pass before a person becomes eligible for coverage under this plan.

Eligible Provider - The following are considered Eligible Providers, under this coverage:

Hospital - a licensed short-term, acute care general Hospital that:

- provides Inpatient services and is compensated by or on behalf of its patients;
- provides surgical and medical facilities primarily to diagnose, treat, and care for the injured and sick; except that a psychiatric Hospital will not be required to have surgical facilities;
- has a staff of Physicians licensed to practice medicine; and
- provides 24-hour nursing care by registered graduate nurses

A facility that serves, other than incidentally, as a nursing home, Custodial Care home, health resort, rest home, rehabilitation facility, or place for the aged is not considered a Hospital.

Other Facility Providers - those providers listed below who are licensed to perform Covered Services in the state where the services are provided:

- Freestanding Dialysis Facility
- Ambulatory Surgical Facility
- Skilled Nursing Facility
- Substance Abuse Treatment Facility
- Residential Treatment Facility
- licensed birthing center
- other facilities approved by BCBST's Medical Director and licensed to provide Covered Services (such as a Freestanding Radiology Facility).

Physician - a licensed Physician legally entitled to practice medicine and perform Surgery.

All Physicians must be licensed in Tennessee or in the state in which Covered Services are rendered.

Other Professional Providers - may provide services covered by this plan. In order to be covered, all services rendered must fall within the provider's specialty and be those normally provided by a Provider within this specialty or degree. All services or supplies must be rendered by the Provider actually billing for them.

- The Provider must be licensed or certified by the state in which they are practicing;
- services provided must be within the scope of his/her licensure; and
- coverage of the provider must be required by state law of the state in which he/she is practicing; or
- be a Provider (such as Physician Assistants) approved by BCBST.

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:

- serious impairment of bodily functions; or
- serious dysfunction of any bodily organ or part; or
- placing a prudent layperson's health in serious jeopardy.

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

Emergency Admission - means admission as an Inpatient in connection with an Emergency.

Emergency Services - Health care services and supplies furnished in a Hospital that are required to determine, evaluate and/or treat an Emergency medical condition until such condition is stabilized, as directed or ordered by a Physician or Hospital protocol.

Employee - is a person who meets the Eligibility requirements and makes application for coverage under this plan.

Employer - A corporation, partnership, union or other entity that is eligible for group coverage under State and Federal laws; and that enters into an Agreement with the administrator to provide Coverage to its Employees and their Eligible Dependents.

Enrollment Date - the Effective Date of a Member's coverage or, if earlier, the first day of the applicable Eligibility Waiting Period.

Explanation of Benefits (EOB) - the form we send after a claim has been filed that tells You what services were covered and which, if any, were not.

Family Deductible - is the maximum dollar amount of Covered Services stated in the Schedule of Benefits that must be incurred and paid by a Subscriber and his or her eligible Dependents before benefits are payable for all or part of the remaining Covered Services.

Family Out-of-Pocket Maximum - means the dollar amount stated in the Schedule of Benefits for which a Subscriber and his or her covered eligible Dependents are responsible to pay for Covered Services during a Calendar Year. This Maximum can be satisfied by a combination of services provided by Network and Out-of-Network Providers.

Freestanding Diagnostic Laboratory - refers to an Other Provider that provides laboratory analysis for all Providers.

Freestanding Dialysis Facility - a facility Other Provider that provides kidney dialysis treatment, maintenance, and training to patients on an Outpatient or Home Health Care basis.

To be eligible for payment under this coverage, the facility must be approved by Medicare.

Health Care Professional - means a podiatrist, dentist, chiropractor, nurse midwife, registered nurse, optometrist, or other person licensed or certified to practice a health care profession, other than medicine or osteopathy, by Tennessee or the state in which such provider practices.

Home Health Care Agency - an organization that provides health care services in a Member's home.

Home Infusion Therapy - means therapy in which fluid or medication is given intravenously. It includes total parenteral nutrition, enteral nutrition, hydration therapy, chemotherapy, aerosol therapy and intravenous drug administration.

Hospice - means a public agency or private organization that provides services for a terminally ill patient in a home environment.

Approved Hospice refers to a Hospice that:

- is licensed by and, if legally required, has been issued a Certificate of Need from the state in which it is operating,
- is certified as a Home Health Care Agency under Title XVIII and Title XIX of the Social Security Act,
- is eligible for accreditation by the Joint Commission on Accreditation of Healthcare Organizations as a Hospice, and
- provides in-home health care services that conform to the standards of a Hospice Program of Care as adopted by the Board of Directors of the National Hospice Organization.

Hospice Home Care - means Medically Necessary medical services rendered to a terminally ill patient in a home environment. Services must be provided by a Physician-supervised team of professionals and volunteers on 24-hour call. Bereavement services to the family must be available.

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.

Inpatient - an individual who is admitted as a registered bed patient in a Hospital or Skilled Nursing Facility and for whom a room and board charge is made.

This term is also used to describe services provided in a Hospital or Skilled Nursing Facility setting.

In-Transplant Network Institution – A facility or hospital that has contracted with the administrator (or with an entity on behalf of the administrator) to provide Transplant Services for some or all organ and bone marrow transplant procedures Covered under this EOC. 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.

Institution - a Hospital, Skilled Nursing Facility, or other facility licensed to provide Covered Services, as specified in this plan.

Investigational Services – A drug, device, treatment, therapy, procedure, or other service or supply that does not meet the definition of Medical Necessity or:

- 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
- is the subject of a current Investigational new drug or new device application on file with the FDA, or
- 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
- 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 conventional alternatives, or

- 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
- in the predominant opinion of experts, as expressed in the published authoritative literature, that usage should be substantially confined to research settings, or
- 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
- the service or supply is required to treat a complication of an experimental or Investigational Service.

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

- Your medical records, or
- the protocol(s) under which proposed service or supply is to be delivered, or
- any consent document that You have executed or will be asked to execute, in order to receive the proposed service or supply, or
- 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
- regulations and other official publications issued by the FDA and HHS, or
- the opinions of any entities that contract with the Plan to assess and coordinate the treatment of Members requiring non-Investigational Services, or

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

The Medical Director's decision may be appealed to the Employer, which has final authority on any decision affecting the Plan.

Late Enrollee - an Employee or eligible Dependent who did not apply, or for whom application was not made, for coverage within 31 days after such person first became eligible for coverage under this plan.

Limiting Age (or Dependent Child Limiting Age) - the age after which a child will no longer be considered an eligible Dependent.

Maximum Allowable Charge - The amount that the administrator, 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 administrator's fee schedule for the Covered Services.

Medical Director - the Physician designated by the administrator, or that Physician's designee, who is responsible for the administration of the administrator's medical management programs, including its Prior Authorization program.

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

- be Medically Necessary.
- be used to diagnose or treat a Member's condition caused by disease, injury or congenital malformation.
- be consistent with current standards of good medical practice for the Member's medical condition.
- be provided in the most appropriate site and at the most appropriate level of service for the Member's medical condition.
- on an ongoing basis, have a reasonable probability of:
 - correcting a significant congenital malformation or disfigurement caused by disease or injury.

- preventing significant malformation or disease.
- substantially improving a life sustaining bodily function impaired by disease or injury.
- not be provided solely to improve a Member's condition beyond normal variations in individual development and aging including:
 - comfort measures in the absence of disease or injury.
 - improving physical appearance that is within normal individual variation.
- not be for the sole convenience of the Provider, Member or Member's family.

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:

- in accordance with generally accepted standards of medical practice; and
- clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the patient, physician or other health care provider; and
- 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.

Medicare – Title XVIII of the Social Security Act, as amended.

Member, You, Your - Any person enrolled as a Subscriber or Covered Dependent under the Plan.

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 administrator may require proof that You have made any required Member Payment.

Mental Disorder - means a condition characterized by abnormal functioning of the mind or emotions and in which psychological, intellectual, emotional, or behavioral disturbances are the dominant feature. Mental Disorders include mental illnesses, mental conditions, and psychiatric conditions, whether organic or non-organic, whether of biological, non-biological, genetic chemical or non-chemical origin, and irrespective of cause, basis or inducement.

Network Hospitals - Hospitals with which BCBST has entered into a Participating Hospital Agreement.

Network Provider - refers to an Institution, Physician, Outpatient mental health facility, Outpatient physical therapy facility, Home Health Agency, Pharmacy, Physician, or Other Provider of health care services, that, at the time a Member receives Covered Services has an agreement with BCBST (or entity contracting with BCBST) to provide those health care services to Members under this plan. A Network Provider may bill or seek reimbursement for Authorized Services from BCBST, except for the Member's Deductibles, Copayments, or Coinsurance amounts.

Other Providers - the following providers may also provide services covered under the plan:

- suppliers of Durable Medical Equipment, appliances, and prosthesis;
- suppliers of oxygen;
- certified Ambulance service;
- Hospice;
- Pharmacy;
- Freestanding Diagnostic Laboratory;
- Home Health Care Agency; and/or
- freestanding and mobile diagnostic or physical therapy facility.

Out-of-Network Provider - a Physician, Hospital, or Other Provider that has not contracted with BCBST to furnish services and to accept BCBST's payment, plus applicable Deductibles and Copayments, as payment in full for Covered Services.

Out-of-Pocket Maximum - means the dollar amount stated in the Schedule of Benefits for which a Member is responsible for Covered Services during a Calendar Year. This maximum can be satisfied by a combination of charges for Covered Services from Network or Out-of-Network Provider's eligible charges, including the Deductible; however, this does not include Psychiatric Care or charges in excess of the Maximum Allowable Charge.

When the Network Out-of-Pocket Maximum is reached, 100% is payable for other Covered Services received from a Network Provider during the remainder of the Calendar Year. However, the Out-of-Network Out-of-Pocket Maximum must be reached before 100% is payable for other Covered Services received from an Out-of-Network Provider during the remainder of the Calendar Year.

Outpatient - an individual who receives services or supplies while not an Inpatient.

This term is also used to describe services provided in an Emergency room, Ambulatory Surgical Facility, Physician's office, or clinic.

Outpatient Surgery - Surgery performed in an Outpatient department of a Hospital, in a Physician's office, or Facility Other Provider.

Physician - means a licensed Physician legally entitled to practice medicine and perform Surgery. All Physicians must be licensed in Tennessee or in the state in which Covered Services are rendered.

Pre-admission Testing - x-rays, electrocardiograms, and laboratory tests made on an Outpatient basis before admission to the Hospital.

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 Waiting Period, for which medical advice, diagnosis, care or treatment was recommended or received.

The following are not Pre-Existing Conditions:

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

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

Pre-existing Condition Waiting Period - the period stated in the Schedule of Benefits of not more than 12 months that begins on the Member's Enrollment Date and during which benefits are not available for services received in connection with a Pre-existing Condition.

The Pre-existing Condition Waiting Period will be reduced by the periods(s) of Creditable Coverage occurring within 18 months before the Enrollment Date (provided there is no break of 63 days or more during which the Member was not covered under any Creditable Coverage).

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

Qualified Medical Child Support Order – A medical child support order, issued by a court of competent jurisdiction or state administrative agency that creates or recognizes the existence of a child's right to receive benefits for which a Subscriber is eligible under the Plan. 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.

Residential Treatment Facility - a Facility-Other-Provider primarily engaged in providing treatment for alcoholism and drug abuse. A Residential Treatment Facility must be licensed, accredited by the Joint Commission on Accreditation of Healthcare Organizations, and be recognized by us.

Service Area - includes those geographic areas in which Covered Services from Network Providers are available.

Skilled Nursing Facility - provides convalescent and rehabilitative care on an

Inpatient basis. Skilled nursing care must be provided by or under the supervision of a Physician. Neither:

- a facility that primarily provides minimal, custodial, ambulatory, or part time care, nor
- a facility that treats mental illness, alcoholism, drug abuse, or pulmonary tuberculosis

will be considered a Skilled Nursing Facility under this plan.

Special Care Unit - those areas of a Hospital where necessary supplies, medications, equipment, and a skilled staff are available to provide care to critically or seriously ill patients who require constant observation.

Subscriber - an Employee who has satisfied the eligibility requirements and has been enrolled for coverage under this plan.

Substance Abuse Treatment Facility - a provider of continuous, structured 24-hour-per-day programs of Inpatient treatment and rehabilitation for drug dependency or alcoholism. A Substance Abuse Treatment Facility must be licensed to provide this type of care by the state in which it operates and be recognized by us.

Surgery - means the following:

operative and cutting procedures, including:

- use of special instruments,
- endoscopic examinations (the insertion of a tube to study internal organs), and
- other invasive procedures;
- treatment of broken and dislocated bones;
- usual and related pre- and post-operative care when billed as part of the charge for Surgery; and
- other procedures that have been approved by us.

Totally Disabled or Total Disability – Either:

- An Employee who is prevented from performing his or her work duties and is unable to engage in any work or other gainful activity for which he or she is qualified or could reasonably become qualified to perform by reason of education, training, or experience because of injury or disease; or

- A Covered Dependent who is 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.

Transplant Maximum Allowable Charge (TMAC) – The amount that the Plan, at its sole discretion, has determined to be the maximum amount payable for Organ Transplants. Each type of Organ Transplant has a separate TMAC. That determination will be based upon the contract with a Transplant Network Provider or the amount payable based on the fee schedule for the Covered Services rendered by Out-of-Network Providers.

Transplant Services – Medically Necessary and Appropriate Services listed as Covered under the Transplant Services section of this EOC.

Waiting Period – The time that must pass before an Employee or Dependent is eligible to be Covered for benefits under 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.

IMPORTANT NOTICE FOR MASTECTOMY PATIENTS

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 Covered Services section of this EOC for details.

NOTICE REGARDING CERTIFICATES OF CREDITABLE COVERAGE

This Plan contains a Pre-Existing Condition Exclusion, which 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.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

You may continue Your Coverage and Coverage for Your Dependents during military leave of absence in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994. When You return to work from Your military leave of absence, You will be given credit for the time You were covered under the Plan prior to the leave. Check with Your Employer to see if this provision will apply to You.

Use this space for information You'll need when asking about Your coverage.

The company office or person to contact about coverage is:

Name:

Address:

Phone:

The BlueCross BlueShield Plan to contact is:

Address: BlueCross BlueShield of Tennessee
1 Cameron Hill Circle
Chattanooga, TN 37402

The Subscriber Number shown on my identification card is:

The "Effective Date" when my coverage begins is:

® Registered marks of the BlueCross BlueShield Association, an Association of Independent BlueCross BlueShield Plans

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