Health Benefit Plan Evidence of Coverage

SUMNER COUNTY EMPLOYEES INSURANCE TRUST FUND-Option 1 - 2016

of Tennessee

Employer Sponsored Plan
Administered by BlueCross BlueShield of Tennessee, Inc. (BlueCross)
Notice to Member:

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.,
ADMINISTRATOR
1 CAMERON HILL CIRCLE
CHATTANOOGA, TENNESSEE 37402
(800) 565-9140

NOTICE TO GO OUT TO ALL EMPLOYEES AGE 60 AND OVER

ACTIVE EMPLOYEES AND ELIGIBLE DEPENDENTS AGE 64 AND UNDER

If You and Your eligible Dependents are covered as an active Employee, NOT CONSIDERED A RETIREE OR A DEPENDENT OF A RETIREE, You must file Your claims with Sumner County's BlueCross BlueShield of Tennessee medical plan.

It is very important that You show Your Sumner County BlueCross BlueShield of Tennessee Medical ID Card every time You receive services from any provider and show your Prescription Benefit Card when purchasing prescriptions. Failure to do so can cause long delays in processing Your claim and can be more costly for You and the County.

ACTIVE EMPLOYEES AND ELIGIBLE DEPENDENTS AGE 65 AND OVER

If You and Your eligible Dependents are covered as an active Employee, NOT CONSIDERED A RETIREE OR A DEPENDENT OF A RETIREE, regardless of age, You must file Your claims with Sumner County's BlueCross BlueShield of Tennessee medical plan FIRST.

It is very important that You show Your Sumner County BlueCross BlueShield of Tennessee Medical ID Card every time You receive services from any provider and show your Prescription Drug Card when purchasing prescriptions. Failure to do so can cause long delays in processing Your claim and could create serious financial consequences for the County with Medicare.

RETIREES AND ELIGIBLE DEPENDENTS AGE 64 AND UNDER

If You or Your eligible Dependents are covered as a retiree, NOT CONSIDERED AN ACTIVE EMPLOYEE OR A DEPENDENT OF AN ACTIVE EMPLOYEE, You must file Your claims with Sumner County's BlueCross BlueShield of Tennessee medical plan.

It is very important that You show Your Sumner County BlueCross BlueShield of Tennessee Medical ID Card every time You receive services from any provider and show your Prescription Benefit Card when purchasing prescriptions. Failure to do so can cause long delays in processing Your claim and can be more costly for You and the County.

RETIREES AND ELIGIBLE DEPENDENTS AGE 65 AND OVER

NOTE: THERE IS NO COVERAGE FOR RETIREES OR THEIR DEPENDENTS WHO ARE OVER AGE 65 PROVIDED BY THE COUNTY.

If You or Your eligible Dependents are considered a retiree, NOT CONSIDERED AN ACTIVE EMPLOYEE OR A DEPENDENT OF AN ACTIVE EMPLOYEE, You must file Your claims with Medicare.

It is very important that You show Your Sumner County BlueCross BlueShield of Tennessee Medical ID Card every time You receive services from any provider and show your Prescription Benefit Card when purchasing prescriptions. Failure to do so can cause long delays in processing Your claims with Medicare.

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INTRODUCTION

This Evidence of Coverage (this "EOC") was created for Your Employer as part of its Employee welfare plan (the "Plan"). References in this EOC to the "Administrator" mean BlueCross BlueShield of Tennessee, Inc., or BlueCross. The pronouns "we", "us", and "our" used throughout this EOC refer to BlueCross. Your Employer has entered into an Administrative Services Agreement (ASA) with BlueCross for it to administer the claims Payments under the terms of the EOC, and to provide other services. BlueCross does not assume any financial risk or obligation with respect to Plan claims. BlueCross is not the Plan Sponsor, or, the Plan Administrator. Your Employer is the Plan Fiduciary, the Plan Sponsor and the Plan Administrator.

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 YOUR RIGHTS AND DUTIES AS A MEMBER. IT IS IMPORTANT TO READ THE ENTIRE EOC. CERTAIN SERVICES ARE NOT COVERED BY THE PLAN. OTHER COVERED SERVICES ARE 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 BENEFIT.

Employer has delegated discretionary authority to make any benefit determinations to the administrator the Employer retains the authority to make any final determination. The Employer, as the Plan Administrator, also has the authority to construe the terms of Your Coverage. The Plan shall be deemed to have properly exercised that authority unless it abuses its discretion when making such determinations. The Employer retains the authority to determine whether You or Your dependents are eligible for Coverage.

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 Customer Service Representatives, at the number listed on Your ID card, if You have any questions when reading this EOC. The Customer Service Representatives are also available to discuss any other matters related to Your Coverage from the Plan.

INDEPENDENT LICENSEE OF THE BLUECROSS BLUESHIELD ASSOCIATION

BlueCross is an independent corporation operating under a license from the BlueCross BlueShield Association (the "Association"). That license permits BlueCross to use the Association's service marks within its assigned geographical location. BlueCross 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 administrator does 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, 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, 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 -
Sumner County Employees Insurance Trust Fund

Group Number: 88230

Benefits Effective: July 1, 2016

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, BlueCross has negotiated agreements with Hospitals under which BlueCross receives a discount on Hospital bills. In addition to such discounts, BlueCross 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 BlueCross 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 BlueCross at the telephone number shown on Your identification card before services are provided. Otherwise, Your benefits may be reduced or denied.

A Clinical Trial is a prospective biomedical or behavioral research study of human subjects that is designed to answer specific questions about biomedical or behavioral interventions (vaccines, drugs, treatments, devices, or new ways of using known drugs, treatments, or devices). Clinical Trials are used to determine whether new biomedical or behavioral interventions are safe, efficacious, and effective. **Routine patient care associated with an approved Clinical Trial will be Covered under the Plan's benefits in accordance with the Plan's medical policies and procedures.**

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

DEDUCTIBLE

Deductible to be applied to:	Network Provider	Out-of-Network Provider
All Covered Services (unless otherwise specified)	$375	$575
Family Deductible Maximum	$1,125	$1,725

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 a Out-of-Network Provider will be significantly less than benefits available for services received from a Network Provider. For services received from a 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 Facility Covered Services after Deductible has been satisfied (unless otherwise specified)	90%	70%
Professional Provider Covered Services***** after Deductible has been satisfied (unless otherwise specified)	90%	70%
***Professional Provider Covered Services include all Covered Services provided at the Provider's office for routine Office Visits and/or Consultations (if Consultations are not considered on the same basis as a routine Office Visit).**		
Emergency Room Services*	90%, subject to the Deductible and a $200 Copayment	70%
***The $200 Copayment is waived if admitted to the Hospital as a bed patient and will not apply to any other Deductible or Out-of-Pocket Maximum.**		
All Other Covered Services after Deductible has been satisfied (unless otherwise specified)	80%	60%
Preventive Services Physical Exams (6 years and older) Routine Pap Smear, and Prostate Exam	100% 100%	**Preventive Services are not available**
Mammograms	100%	**Preventive Services are not available**
Hearing Aids (for anyone over the age of 19) Limited to $6,000 every 3 years.	80%	60%
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:

Maximum to be applied to:	Network Provider	Out-of-Network Provider
Individual	$2,575	$7,575
Family	$7,725	$15,150

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**: 70% 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**: 70% 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.
Network Providers not in our Transplant Network include Network Providers in Tennessee and BlueCard PPO Providers outside Tennessee.			

The Maximum Amount Payable for Network and/or Non-Network Provider Services is unlimited.

OTHER PROVISIONS

- Employees who are new enrollees, have loss of other Coverage, or are participating in open enrollment to the Sumner County Employees Insurance Trust Benefit Plan on or after January 1, 2006, must participate in the CareHere Health Risk Assessment before health Coverage becomes effective.

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
- Hospice Home Care

SPECIAL PROVISIONS

Benefits are available for Positron Emission Tomography (PET) scan when performed:

- as a follow-up evaluation of brain tumors to assess the possibility of malignant degeneration; or
- in epilepsy cases, as a pre-surgical evaluation of chronic refractory seizures believed to be partial seizures.

PRESCRIPTION DRUG PROGRAM

1. Benefit Payment

Generic Drugs: 10% with maximum of $30 or actual cost of drug, whichever is less, Drug Copayment per 34 day supply.

Preferred Brand Drugs: 25% with maximum of $70 or actual cost of drug, whichever is less, Drug Copayment per 34 day supply.

Non-Preferred Brand Drugs: 35% with maximum of $120 or actual cost of drug, whichever is less, Drug Copayment per 34 day supply.

Subject to a Calendar Year Out-of-Pocket Maximum of:-Unlimited.

No Drug Deductible, Drug Copayment or maximum amounts apply to satisfying any Deductible, Coinsurance or maximums in the Plan.

Benefit payment for Covered Services will be determined as follows:

Generic Drug Benefit:

- At the Network Pharmacy, You will pay Your Copayment. There may be occasions when You pay less than the Copayment.

Preferred Brand Drug:

- At the Network Pharmacy, You will pay Your Copayment. There may be occasions when You pay less than the Copayment.

Non-Preferred Brand Drug:

- At the Network Pharmacy, You will pay Your Copayment. There may be occasions when You pay less than the Copayment.

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

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.

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 Drug Deductible, Coinsurance, and/or Drug Copayment amount.

2. Covered Services

a. Prescription Drugs prescribed when You are not confined in a hospital or other facility. Prescription Drugs must be:

   – prescribed on or after Your Coverage begins;

   – approved for use by the Food and Drug Administration (FDA);

   – dispensed by a licensed pharmacist;

   – listed on the Preferred Formulary; and

   – not available for purchase without a Prescription.

b. Treatment of phenylketonuria (PKU), including special dietary formulas while under the supervision of a Practitioner.

c. Injectable insulin, and insulin needles/syringes, lancets, alcohol swabs and test strips for glucose monitoring upon Prescription.

d. Prescription and over-the-counter (OTC) nicotine replacement therapy and aids to smoking cessation including, but not limited to, patches, except as required by the Affordable Care Act.

e. Medically Necessary Prescription Drugs used during the induction or stabilization/dose-reduction phases of chemical dependency treatment.

3. 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. Any Prescription and non-Prescription medical supplies, devices and appliances, other than syringes used in conjunction with injectable medications or other supplies used in the treatment of diabetes and/or asthma;

e. Immunizations or immunological agents, including but not limited to: (1) biological sera, (2) blood, (3) blood plasma; or (4) other blood products except as required by hemophiliacs; and,

f. Injectable drugs, except when: (1) intended for self-administration; or (2) directed by the Administrator.

g. Compound Drugs are only Covered 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 at least one ingredient in the Compound Drug.

h. Prescription Drugs that are commercially packaged or commonly dispensed in quantities less than a 30-calendar day supply (e.g. prescription items that are dispensed based on a certain quantity for a therapeutic regimen) will be subject to one Drug Copayment, provided the quantity does not exceed the FDA-approved dosage for four calendar weeks.

i. 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.

j. 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.

k. 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.

l. 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.

4. Exclusions

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

a. Prescription Drugs not on the Drug Formulary - Preferred;

b. drugs which 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 quantity of Prescription Drugs which exceed that specified by the Plan's P & T Committee;

d. any Prescription Drug purchased outside the United States, except those authorized by Us;

e. contraceptives which require administration or insertion by a Provider, except as otherwise Covered in the EOC;

f. medications intended to terminate a pregnancy;

g. non-medical supplies or substances, including support garments, regardless of their intended use;

h. artificial appliances;

i. allergen extracts;

j. any drugs or medicines dispensed more than one year following the date of the Prescription;

k. Prescription Drugs You are entitled to receive without charge in accordance with any worker's compensation laws or any municipal, state, or federal program;

l. replacement Prescriptions resulting from lost, spilled, stolen, or misplaced medications (except as required by applicable law);

m. drugs dispensed by a Provider other than a Pharmacy or dispensing Physician;

n. Prescription Drugs used for the treatment of infertility;

o. 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;

p. anorectics (any drug or medicine for the purpose of weight loss and appetite suppression);

q. 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;

r. Prescription Drugs used for cosmetic purposes including, but not limited to: (1) drugs used to reduce wrinkles; (2) drugs to promote hair-growth; (3) drugs used to control perspiration; (4) drugs to remove hair; and (5) fade cream products;

s. Prescription Drugs used during the maintenance phase of chemical dependency treatment, unless Authorized by Us;

t. 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;

u. Specialty Drugs used to treat hemophilia filled or refilled at an Out-of-Network Pharmacy; drugs used to enhance athletic performance;

v. Experimental and/or Investigational Drugs;

w. Provider-administered Specialty Drugs, as indicated on Our Specialty Drugs list;

x. Prescription Drugs or refills dispensed:

- in quantities in excess of amounts specified in the Benefit payment section;
- without Our Prior Authorization when required; or
- which 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.

5. DEFINITIONS

1. **Average Wholesale Price** – A published suggested wholesale price of the drug by the manufacturer.

2. **Brand Name Drug** - a Prescription Drug identified by its registered trademark or product name given by its manufacturer, labeler or distributor.

3. **Compound Drug** - An outpatient Prescription Drug, which is not commercially prepared by a licensed pharmaceutical manufacturer in a dosage form approved by the Food and Drug Administration (FDA) and which contains at least one ingredient classified as a Legend Drug.

4. **Drug Copayment** - The dollar amount specified herein 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.

5. **Drug Formulary** - Preferred - A list of specific generic and brand name Prescription Drugs Covered by the Administrator subject to Quantity Limitations , Prior Authorization, Step Therapy[, over-the-counter alternative limitations and generic equivalent or therapeutic alternative limitations]. The Drug Formulary is subject to periodic review and modification at least annually by the Administrator's Pharmacy and Therapeutics Committee. The Drug Formulary is available for review at bcbst.com, or by calling the toll-free number shown on the back of Your Member ID card.

6. **Experimental and/or Investigational Drugs** – Drugs or medicines, which are labeled: "Caution – limited by federal law to Investigational use."

7. **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.

8. **Home Delivery Network** – BlueCross BlueShield of Tennessee's (BlueCross) network of pharmaceutical providers that deliver prescriptions through mail service pharmacy facilities providers to Your home.

9. **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."

10. **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 home delivery.

11. **Non Preferred Brand Drug or Elective Drug** - a Brand Name Drug which is not considered a Preferred Drug by the administrator. Usually there are lower cost alternatives to some Brand Name Drugs.

12. **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.

13. **Pharmacy** - a state or federally licensed establishment which 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.

14. **Pharmacy and Therapeutics Committee or P&T Committee** - A panel of the Administrator's participating pharmacists, Network Providers, medical directors and pharmacy directors which 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 Drug list; and (5) Quantity Limitation list. The P&T Committee may also set dispensing limits on medications.

15. **Plus90** – BlueCross's network of retail pharmacies that are permitted to dispense Prescription Drugs to BlueCross Members on the same terms as pharmacies in the Mail Order Network.

16. **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.

17. **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 a dispensing Physician for a drug, or drug product to be dispensed.

18. **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.

19. **Prior Authorization Drugs** - Prescription Drugs that are only eligible for reimbursement after Prior Authorization from the Administrator as determined by the P&T Committee.

20. **Quantity Limitation** – Quantity limitations applied to certain Prescription Drug products as determined by the P and T Committee.

21. **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 Drugs list. Specialty Drugs are categorized as provider-administered or self-administered.

22. **Specialty Pharmacy Network** – A Pharmacy that has entered into a network pharmacy agreement with the Administrator or its agent to legally dispense self-administered Specialty Drugs to You.

23. **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 health care program. You are called the Subscriber or Member.

COVERAGE FOR YOUR DEPENDENTS

If You are covered by this program, You may enroll Your Eligible Dependents. Your 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 BlueCross 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:

- Employees who are new enrollees, have loss of other Coverage, or are participating in open enrollment to the Sumner County Employees Insurance Trust Benefit Plan on or after January 1, 2006, must participate in the CareHere Health Risk Assessment before health Coverage becomes effective.
- Health Coverage will become effective as outlined in the Plan only after participation in the CareHere Risk Assessment by the eligible employee.
- be a full-time Employee scheduled to work at least 32 or more hours per week, or
- be a school bus driver (scheduled 4.5 or more hours per day, does not include substitute drivers) employed by the Sumner County Board of Education; or
- be a school bus attendant (scheduled 4.5 or more hours per day, does not include substitute attendants); or
- be a school nutrition worker scheduled 5 or more hours per day; or
- be an eligible Dependent of Employees; or
- be an Employee who was covered by insurance through one of the various Employers at the inception of the Trust; or
- be an Employee, who at the inception of employment was covered by insurance, but who has his/her weekly work hours cut to less than 32 due to lack of funds in a particular department; and
- all custodians and childcare staff who are currently receiving benefits and were on the Plan prior to July 1, 2011, will be grandfathered. If these individuals drop from the Plan for any reason they can only return to Coverage under the then-stated eligibility rules for all new hires by classification.

ELIGIBLE EARLY RETIREES AND DISABLED EMPLOYEES – COUNTY GENERAL AND HIGHWAY DEPARTMENT

To be eligible for coverage as an Early Retiree or Disabled Employee, an Employee must meet the eligibility criteria that became effective January 1, 2006, shown below and is not retroactive. Sumner County will pay 75% of the cost of medical insurance premiums for an eligible employee at retirement if the employee meets the following qualifications:

- the eligible Employee must be at least 60 years of age and have 20 years or more of service with Sumner County; or
- the eligible employee, of any age, obtains 30 years of service with Sumner County; and
- the employee must be eligible for medical insurance coverage for the last 5 years of their employment with Sumner County **(1)**; however
- at the time of retirement, if the employee has 5 years continuous employment and the dependent has been eligible to participate in the plan for that five year period, then the dependent can retain coverage as part of the retiree's plan but the dependent must pay 100% of the additional premium cost.

(1) (This does not mean the employee has participated in the insurance plan, but would have been eligible for coverage.)

- due to the restrictions placed by reinsurance: if the employee and/or dependent has not had coverage but has been eligible for the last 5 years and elects to take County Insurance at Retirement, that retiree and/or dependent will be required to answer a questionnaire in order to qualify for health care coverage and if deemed eligible for coverage will be subject to pre-existing conditions.
- a Disabled Employee must be certified as disabled by the Social Security Administration, must have been enrolled in the County Insurance Program at the time of disability, and must have 10 or more years of County service at the time of disability.

The retired Employee is responsible for payment of 25% of the cost of this coverage. Programs to share in the cost for the retired Employee's coverage are the responsibility of the County Group offering the program and not the Insurance Trust.

Coverage under the Sumner County Employees Early Retirement Group ends when the retired Employee attains age 65 or becomes eligible for Medicare.

If, at the time of retirement, the retired Employee has 5 years of continuous employment with Sumner County, and a dependent has been eligible to participate in the Plan for that 5-year period, the dependent can continue coverage as part of the retired Employee's Plan. However, the dependent must pay the entire contribution for this coverage.

ELIGIBLE EARLY RETIREES AND DISABLED EMPLOYEES – BOARD OF EDUCATION

To be eligible for coverage as an Early Retiree or Disabled Employee, an Employee must meet the eligibility criteria for the Early Retiree Medical Insurance Group that became effective January 1, 1994 shown below:

- the Employee must have attained age 55 or older and must have 10 or more years of service with Sumner County; or
- the Employee must have attained age 53 or older and must have 30 years or more of government service (of which 15 or more years is service with Sumner County); or
- a Disabled Employee must be certified as disabled by the Social Security Administration, must have been enrolled in the County Insurance Program at the time of disability, and must have 10 or more years of County service at the time of disability.

The Disabled Employee is responsible for payment of 100% of the premium cost. Programs to share in the premium cost for the Disabled Employee are the responsibility of the County Group offering the program and not the Insurance Trust.

Coverage under the Sumner County Employees Early Retirement Group ends when the Retired or Disabled Employee attains age 65 or becomes eligible for Medicare. If the Retired or Disabled Employee ceases to be eligible, he/she may choose to continue coverage for an eligible Dependent Spouse or eligible Dependent Child(ren) as long as they meet the age criteria and are not eligible for Medicare or other insurance programs.

EFFECTIVE DATE

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

If You have met the eligibility requirements and You and Your Eligible Dependents apply when first eligible (or within 31 days), Your coverage will be effective the first day of the month following your 30 day waiting period. If You and Your Eligible Dependents do not apply when first eligible, You will be subject to the requirements explained in "If You Did Not Enroll On Time" shown on a following page.

You and Your Dependents will not be covered until Your completed application for coverage, listing all eligible Dependents, has been received by BlueCross and You have been issued an identification card or have received other written notice that Your coverage is in effect.

APPLYING FOR COVERAGE

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

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

a. The Subscriber's current spouse as defined by the Employer, which may include a Domestic Partner; or

b. The unmarried, natural, legally adopted, foster or step-child(ren) of the Subscriber or the Subscriber's spouse who is under the age limit stated on the Schedule of Benefits and is dependent upon Subscriber or Subscriber's spouse for at least 50% of his or her support. 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

c. A child of Subscriber or Subscriber's spouse for whom a Qualified Medical Child Support Order has been issued; or

d. An Incapacitated child of the Subscriber or the Subscribers spouse.

e. Adult children (age 18 and over) who have access to their own employer group coverage may not be eligible. Check with Your Employer to find out if this provision applies.

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

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

The Plan's determination of eligibility under the terms of this provision shall be conclusive. The Plan reserves the right to require proof of eligibility including, but not limited to, a certified copy of any Qualified Medical Child Support Order or certification of full-time student status.

Employer agrees to defend or settle, and hold BlueCross 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 Your marital status changes (marriage or divorce) or if there is a change in the number of Your children (birth, adoption), You may want to change Your coverage to one of the other options available.

When You need to make a change, You should (1) tell Your 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 BlueCross bills Your 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.

If You Did Not Enroll On Time

If You wait more than 31 days from the date You are first eligible to apply or add a Dependent You and or the Dependent 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 You or the Dependent will otherwise be effective on the next billing date following our receipt of the application for Coverage.

However, a person will <u>not</u> 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.

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.

ANNUAL OPEN ENROLLMENT

An Open Enrollment Period is established for a one-month period each year whereby Employees can elect coverage without furnishing proof of insurability. The Pre-Existing Waiting Period stated in the Schedule of Benefits will not apply to Members who apply for coverage during such Open Enrollment Period.

SECTION II - INTER-PLAN PROGRAMS

I. Out-of-Area Services

Blue Cross Blue Shield of Tennessee ("BlueCross") has a variety of relationships with other Blue Cross and/or Blue Shield Licensees ("Inter-Plan Programs"). Whenever You obtain healthcare services outside of BlueCross's service area ("Service Area"), the Claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard Program and may include negotiated national account arrangements available between BlueCross and other Blue Cross and/or Blue Shield Licensees.

Typically, when accessing care outside the Service Area, You will obtain care from healthcare Providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, You may obtain care from non-participating Providers. BlueCross's payment practices in both instances are described below.

A. BlueCard® PPO Program

When You are outside the Service Area and need healthcare services or information about Network doctors or hospitals, call 1-800-810-BLUE (2583).

Under the BlueCard® PPO Program, ("BlueCard") when You access Covered Services within the area served by a Host Blue, BlueCross will remain responsible for fulfilling BlueCross's contractual obligations under this Agreement. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

Whenever You access Covered Services outside BlueCross's service area and the claim is processed through BlueCard, the amount You pay for Covered Services is calculated based on the lower of:

- The Billed Charges for Your Covered Services; or
- The negotiated price that the Host Blue makes available to BlueCross.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to Your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with Your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modification noted above. However, such adjustments will not affect the price BlueCross uses for Your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to Your calculation. If any state laws mandate other liability calculation methods, including a surcharge, We would then calculate Your liability for any Covered Services according to applicable law.

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 number on the back of Your Member ID card for Prior Authorization. In case of an Emergency, You should seek immediate care from the closest health care Provider.

B. Negotiated (non-BlueCard Program) National Account Arrangements

As an alternative to the BlueCard Program, Your claims for Covered healthcare services may be processed through a negotiated national account arrangement with a Host Blue.

The amount You pay for Covered healthcare services under this arrangement will be calculated based on the negotiated price/lower of either Covered Billed Charges or negotiated price (Refer to the description of negotiated price under Section A., BlueCard Program) made available to BlueCross by the Host Blue.

C. Non-Participating Healthcare Providers Outside BlueCross's Service Area

1. Member Liability Calculation

   When Covered Services are provided outside of BlueCross's Service Area by non-participating Providers, the amount You pay for such services will generally be based on either the Host Blue's non-participating Provider local payment or the pricing arrangements required by applicable law. In these situations, You may be liable for the difference between the amount that the non-participating Provider bills and the payment BlueCross will make for the Covered Services as set forth in this paragraph.

2. Exceptions

   In certain situations, BlueCross may use other payment bases, such as Covered Billed Charges, the payment We would make if the healthcare services had been obtained within Our Service Area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount BlueCross will pay for services rendered by non-participating Providers. In these situations, You may be liable for the difference between the amount that the non-participating Provider bills and the payment BlueCross will make for the Covered Services as set forth in this paragraph.

D. BlueCard Worldwide® Program

If You are outside the United States, Puerto Rico and the U.S. Virgin Islands, You may be able to take advantage of the BlueCard Worldwide Program when accessing Covered health services. The BlueCard Worldwide Program is unlike the BlueCard Program in certain ways, in that while the BlueCard Worldwide Program provides a network of contracting inpatient hospitals, it offers only referrals to doctors and other outpatient Providers. When You receive care from doctors and other outpatient Providers, You will typically have to pay the doctor or other outpatient Provider and submit a claim to obtain reimbursement for these services.

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.

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

A. Prior Authorization

BlueCross 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 and Hospice 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
- Certain Durable Medical Equipment (DME), certain prosthetics and certain orthotics
- 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.

Network Providers in Tennessee will request Prior Authorization for You.

Network Providers outside of Tennessee are responsible for obtaining Prior Authorization for any inpatient hospital (facility only) stays and outpatient services requiring Prior Authorization. In these situations, the Member is not responsible for any penalty or reduced benefit when Prior Authorization is not obtained.

You are responsible for obtaining Prior Authorization when using In-Network Providers outside of Tennessee for physician and outpatient services and all services from Out-of-Network Providers, or payments may be reduced or services denied.

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

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

Network Providers in Tennessee are required to comply with all of BlueCross'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 <u>not</u> held harmless if:

– A Network Provider outside Tennessee (known as a BlueCard

PPO Participating Provider) fails to comply with Care Management program, or

- An Out-of-Network Provider fails to comply with Care Management program; or
- You sign a Provider's waiver stating You will be responsible for the cost of the treatment, according to the terms of the waiver.

2. 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.

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 Medically 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 BlueCross.

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.

3. 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. BlueCross'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.

4. 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.

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.

HEALTH AND WELLNESS SERVICES

BlueCross provides You with resources to help improve Your health and quality of life through Our interactive Health and Wellness Portal. To learn more about these resources, visit bcbst.com and click on the Health & Wellness tab, or call the number on the back of your Member ID card.

Personal Health Assessment – This assessment tool helps You understand certain health risks and what You can do to reduce them with a personalized wellness report.

Decision Support Tools – With these resources, You can get help with handling health issues, formulate questions to ask Your doctor, understand symptoms and explore health topics and wellness tips that matter to You most.

Self-Directed Health Courses – Our self-guided online health courses help to educate You about common health concerns and how to control them.

Health Trackers – The health trackers program provides You tools and reminders to keep up with Your diet and exercise habits. Progress reminders can be sent through Your preferred communications channel via mail, email, phone or text messaging.

BluePerks[SM] - BluePerks is a discount program with savings of up to 50% on a range of health-related products and services, including fitness equipment, LASIK eye Surgery, massage therapy, hearing aids, travel and recreation, weight loss programs and more.

FitnessBlue[SM] – FitnessBlue is a discount fitness program that is intended to help You get and stay fit with a nationwide network of fitness facilities.

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 which 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-(includes inpatient Hospice)

Room, board, and general nursing care in a:

- room and board; general nursing care; medications, injections, diagnostic services,
- Special Care Unit as approved by BlueCross;
- 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;
- Pre-admission testing; and
- Telehealth.

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.

An observation stay that occurs in conjunction with an ER visit will be subject to Member cost share under the "Outpatient Facility Services" section of "Attachment C: Schedule of Benefits" in addition to Member cost share for the ER visit.

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 which are available with respect to the other covered surgical procedure(s), whether performed through the same or separate incisions.

Assistant Surgeon

Services of an assistant surgeon who actively assists the operating surgeon in performing a covered surgical procedure, when:

- no intern, resident, or other staff doctor is available, and
- in Our opinion, the surgical procedure requires the services of an assistant.

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.
- Telehealth.

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

Allergy Testing

Benefits are available for allergy testing when Medically Necessary and performed by an eligible Provider. No benefits will be provided for services deemed as Experimental or Investigative. (To determine benefit availability, proposed method of testing should be submitted to BlueCross by the attending Physician prior to services being rendered.)

Ambulance

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

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

(paramedic services) without ambulance transportation.

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

Exclusions

- Transportation for Your convenience.
- Transportation that is not essential to reduce the probability of harm to the patient.

Cardiac Rehabilitation Services

Subject to Pre-Treatment Certification Requirements, benefits will be available as stated in the Schedule of Benefits for one Cardiac Rehabilitation Services within a 12-month period. Covered Services include Rehabilitation Services designed primarily to improve functional capacity (three visits per week for up to 12 weeks, or a total of 36 visits, whichever occurs first).

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 BlueCross Medical Necessity guidelines with regard to the frequency and duration of exercise and education programs.

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.

Durable Medical Equipment and Supplies

Benefits are available for the rental and, where deemed appropriate by BlueCross, 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.

(See information about Cost Containment Features that apply to Durable Medical Equipment.)

Eyeglasses or Contact Lenses

- one set following cataract Surgery

Home Health Care

Benefits are available for the following services when prescribed by the Member's 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-Outpatient

(Benefits are provided at 100%, not subject to the Deductible for Hospice Home Care)

- 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.

Mammography Screening

Benefits are available for female Members in accordance with the following schedule:

- Benefits will be provided for one baseline mammogram for each Member between 35 and 40 years of age, and one mammogram every year for Members 40 years of age and older.

Obstetrical and Gynecological Exam

Benefits are available for one examination, including Pap smear, per Benefit Period.

Office Visits for an Illness or Injury

Organ Transplants

As soon as Your Practitioner tells You that You might need a transplant, You or Your Practitioner must contact the administrator's Transplant Case Management department. Call the number on the back of Your Member ID card for Our consumer advisors, and ask to be transferred to Transplant Case Management. A benefit specialist will explain Your transplant benefits including:

- The Transplant Network Institutions available to You so You receive the highest level of benefits
- Your potential cost if an available Transplant Network Institution is not used
- How to use Your travel benefit, if applicable

Transplant Case Management is a mandatory program for those Members seeking Transplant Services.

1. **Prior Authorization**

   Transplant Services require Prior Authorization. Transplant Services or supplies that have not received Prior Authorization will not be Covered. "Prior Authorization" is the pre-treatment approval that must be obtained from Us before any pre-transplant evaluation or any Covered Procedure is performed.

   You or Your Practitioner must contact the administrator's Transplant Case Management department before pre-transplant evaluation or Transplant Services are received.

2. **Benefits**

   (See section 6 below for Kidney transplant benefit information.)

   Transplant benefits are different than benefits for other services. To avoid extra cost, which could be substantial, you must contact Transplant Case Management to be directed to the appropriate Transplant Network Provider.

   If a Transplant Network Institution is not used, benefits may be subject to reduced levels as outlined in Attachment C: Schedule of Benefits. All solid organ and stem cell/bone marrow transplants must meet medical criteria and must be Medically Necessary and Medically Appropriate for the medical condition for which the transplant is recommended.

   You have access to three levels of benefits:

   a. Transplant Network – If you go to a Transplant Network Provider, You will receive the highest level of benefits for Covered Services. The administrator will reimburse the Transplant Network Provider at the benefit level listed in Attachment C: Schedule of Benefits. The Transplant Network Provider cannot bill You for any amount over Your Deductible and Out-of-Pocket Maximum, which limits Your

liability. **Not all Network Providers are in Our Transplant Network. Please check with Transplant Case Management to see which Hospitals are in Our Transplant Network.**

b. Network transplants. If You have the transplant performed outside the Transplant Network, but still at a facility that is a Network Provider or a BlueCard PPO Participating Provider, the administrator will reimburse the Network or BlueCard PPO Participating Provider at the benefit level listed in Attachment C: Schedule of Benefits, limited to a 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 administrator – this amount may be substantial.**

c. Out-of-Network transplants. If You have the transplant performed at a facility that is not a Network Provider or a BlueCard PPO Participating Provider, the administrator will reimburse the Out-of-Network Provider at the benefit level listed in Attachment C: Schedule of Benefits, limited to the Transplant Maximum Allowable Charge. **There is no maximum to Your liability. The Out-of-Network Provider also has the right to bill You for any amount not Covered by the administrator - 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.

3. Covered Services

Benefits are payable for the following transplants if Medical Necessity and Appropriate is determined and Prior Authorization is obtained:

- Kidney
- Kidney/Pancreas
- Pancreas
- Liver
- Heart
- Heart/Lung
- Lung
- Bone Marrow or Stem Cell transplant (allogeneic and autologous) for certain conditions
- Small Bowel
- Multi-organ transplants as deemed Medically Necessary

Benefits may be available for other organ transplant procedures that, in Our discretion, are not experimental or Investigational and that are Medically Necessary and Medically Appropriate.

4. Organ and Tissue Procurement

If a Covered person requires a solid organ or bone marrow/stem cell transplant, the cost of organ and tissue acquisition/procurement is included as part of the Covered person's Covered Expenses. The cost of Donor Organ Procurement is included in the total cost of Your Organ Transplant.

If the donor is not a Member, Covered Services for the donor are limited to the services and supplies directly related to the Transplant Service itself:

- Donor Search
- Testing for donor's compatibility

- Removal of the organ/tissue from the donor's body
- Preservation of the organ/tissue
- Transportation of the tissue/organ to the site of transplant
- Donor follow up care

Donor services are Covered only to the extent not covered by other health coverage. The administrator will cover donor services for initial acquisition/procurement only. Complications, side effects or injuries are not covered unless the donor is a Covered person on the administrator.

5. **Travel Expenses**

Travel Expenses are Covered only if you go to a Transplant Network Institution

Travel expenses are available to a Covered person who receives solid organ or stem cell transplant services at a Transplant Network Institution and:

- An adult to accompany the Covered person or
- One or two parents of the covered person (if the Covered person is a Dependent Child, as defined in this Plan).

Covered travel and lodging expenses must be approved by Transplant Case Management and include the following:

- To and from the Transplant Network Institution for initial Transplant evaluation, including services performed as part of the transplant episode of care prior to the Covered procedure
- To and from the Transplant Network Institution as required by the institution to remain listed for an approved transplant procedure
- To and from the Transplant Network Institution for a Covered transplant procedure and required post-transplant follow-up
- Transportation includes:
  - Mileage for your private car limited to reimbursement at the IRS mileage rate in effect at time of travel
  - Airfare, approved by Transplant Case Management, reimbursed at coach rates
  - Public Transportation
  - Parking Fees
  - Tolls
- Lodging at or near the transplant facility including:
  - Apartment Rental
  - Hotel Rental

  Lodging for purposes of this administrator does not include private residences.
- In order to be reimbursed, travel must be approved by Transplant Case Management. In many cases, travel will not be approved for kidney transplants.
- Approved travel expenses will not apply to the Deductible or Out-of-Pocket Maximum
- Approved travel expenses will be limited as stated below.
  - Meals and lodging expenses, limited to $150 per day.
  - The aggregate limit for travel expenses is $10,000.

6. Kidney Transplants

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

There are two levels of benefits for kidney transplants: Network and Out-of-Network:

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

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

7. Exclusions

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

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

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

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

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

e. Non-Covered Services;

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

g. Any non-human, artificial or mechanical organ not determined to be Medically Necessary;

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. 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;

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

k. 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.

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 Services

Benefits are available for the following services only when provided by a Network Provider as outlined in the Schedule of Benefits:

Child Health Supervision Services. Benefits include history, physical examination, developmental assessment, anticipatory guidance, and appropriate immunization and laboratory tests, in keeping with prevailing medical standards, for Members under six (6) years of age, subject to the following guidelines:

- Under age one: 4 physical examinations per 12-month period (in addition to the initial Physician exam in the Hospital (otherwise covered under the health plan).
- Age one (1) year: (2) physical examinations per 12 month period
- Age two to six years of age: 1 physical examination per 12 month period

Physical Examination.

Benefits are available for Members age 6 years of age or older for one physical examination per 12-month period. (Female Members may elect to have such exam provided by an Obstetrician/Gynecologist.)

Lab tests recognized by the Guide to Clinical Preventive Services as reported by the U.S. Preventive Health Task Force, including but not limited to the following:

Lipid Profile:

total blood cholesterol, HDL, LDL and triglycerides

Blood Sugar

Hematocrit (blood count)

Urinalysis

Resting Electrocardiogram

Stool for occult blood.

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

- **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 which involves the continuous slow introduction of a solution into the body
- **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 if ordered by a physician and performed by a qualified occupational therapist
- **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.

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 which we determine 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 which is Experimental or Investigational (see Section VIII, Definition of Terms)
5. any work related illness or injury (unless resulting from self-employment not subject to Workers Compensation insurance requirements)
6. services or supplies furnished without cost under the laws of any government except Medicaid (TennCare^{SM}) 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 which 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 Blue Cross or Blue Shield group ASA, 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 which are primarily for diagnostic studies
17. whole blood, blood components, and blood derivatives which 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
23. eyeglasses, contact lenses, and examinations for and the fitting of eyeglasses and contact lenses, except as otherwise specified.
24. Hospital admissions primarily for physical therapy

    (Physical therapy is covered where there is another primary diagnosis.)
25. rehabilitative services of any kind, including, but not limited to, hydrotherapy, educational or occupational therapy

    (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 shall not be covered under this Plan.)
26. Surgery to change sex, and related services
27. 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 which 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.
28. services covered under Medicare, except as required by applicable state or federal law
29. non-medical self-care or self-help training and any related diagnostic testing or medical social services
30. 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)
31. an artificial heart or any other artificial organ, or any associated expense
32. services or supplies for the reversal of sterilization
33. services or supplies incurred after a Concurrent Review determines the services and supplies are no longer Medically Necessary
34. charges in excess of the Maximum Allowable Charge for a service or supply
35. services rendered for or in connection with physical therapy which 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
36. any balance of charges, Deductibles, or Coinsurance resulting from a Member's failure to comply with applicable requirements of any other individual or group contract, including: Prior Authorization, second surgical opinion consultation, Outpatient Surgery, or concurrent care review programs
37. services or supplies for Inpatient treatment of bulimia, anorexia, or other eating disorders which consist primarily of behavior modification, diet and weight monitoring, and educational services
38. services or supplies in connection with treatment of obesity
39. any charges for services and supplies rendered to a Member which require the Approval of BlueCross BlueShield of Tennessee, where such Approval 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 which 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 which 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. Human growth hormones, unless covered under the Prescription Drug program in this EOC.

55. Methadone and methadone maintenance therapy.

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 the Member. 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 a Non-Network Provider for Covered Services rendered by that Provider. If You use a Non-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 in the same manner as described above for Non-Network Providers. You also have the same responsibilities as described above.

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 a Non-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.

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 In-Network Benefit level.

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

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 was 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.

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 Your company's Benefits Manager.

SECTION VII - GRIEVANCE

GRIEVANCE PROCEDURE

I. INTRODUCTION

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

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

  - 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.

- Providers may also appeal an Adverse Benefit Determination through Our Provider dispute resolution procedure.
- 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.
- You may request a form from the Plan to authorize another person to act on Your behalf concerning a Dispute.
- 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.
- 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. BlueCross is a limited fiduciary for the first level Grievance.

- **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.

- **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.

- **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.

- **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 legal action shall be brought to recover under this EOC until 60 days after the claim has been filed. No such legal action shall be brought more than 3 years after the time the claim is required to be filed.

SECTION VIII - 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.

<u>Notice and Cooperation</u>

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 IX - TERMINATION OF MEMBER COVERAGE

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

BlueCross 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.

1. 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.

2. Termination of Coverage for Cause

The Plan may terminate Your Coverage for cause, if:

1. 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

a. You act in such a disruptive manner as to prevent or adversely affect the ordinary operations of the Plan; or

b. You fail to cooperate with the Plan or Employer as required; or

c. 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.

3. 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.

4. 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. <u>Eligibility</u>

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.

- 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.

b. 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.

c. 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.

d. 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.

e. 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.

f. 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.

g. 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.

h. 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. 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 X - 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 BlueCross and the Employer. It includes the ASA and any attached papers or riders (including the Letter of Intent, if any).

Adverse Benefit Determination – Any denial, reduction, termination or failure to provide or make payment for what You believe should be a Covered Service. Adverse Benefit Determinations include:

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

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

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

Allied Health Professional - is a health care provider, other than a Physician, who has entered into a contract with BlueCross 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 which 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.

Annual Benefit Period – The 12-month period under which Your benefits are administered, as noted in the Schedule of Benefits.

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 Medically 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 BlueCross 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.

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 a 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 BlueCross'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 BlueCross'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

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 Medically 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

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 two people) and unmarried children including adopted children and stepchildren who live with the Subscriber in a regular parent-child or guardianship relationship and are dependent on them for at least 50 percent of their support.

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

Durable Medical Equipment - equipment which:

- 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 which 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 BlueCross'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 BlueCross.

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

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 which 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, except Outpatient Psychiatric Services.

Freestanding Diagnostic Laboratory - refers to an Other Provider, which 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.

Health Risk Assessment – The CareHere Health Risk Assessment report includes personal health responses and lab results from a blood draw. The report is valuable in reporting and following your health status. You can discuss the report with the CareHere physician. All Health Risk Assessment information is private, confidential, and no manager or employee with Sumner County will have access to your personal report. Lab testing at locations other than CareHere is not valid because the CareHere Health Risk Assessment includes a defined comprehensive set of lab tests that are frequently not included in routine testing.

To schedule a Health risk Assessment, contact CareHere at 1-800-473-1330 or register online at www.CareHere.com and click "Members Only." First time registrants should use an Access Code of SC327.

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 which:

- 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, which 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 or physical disability (what used to be called mental retardation or physical handicap); and (2) chiefly dependent upon the Subscriber or Subscriber's spouse for economic support and maintenance.

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.

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. We may ask You to furnish proof of the incapacity and dependency upon enrollment and 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 – The definition of "Investigational" is based on the BlueCross and BlueShield of Tennessee's technology evaluation criteria. Any technology that fails to meet **ALL** of the following four criteria is considered to be investigational.

- The technology must have final approval from the appropriate governmental regulatory bodies, as demonstrated by:
  - i. This criterion applies to drugs, biological products, devices and any other product or procedure that must have final approval to market from the U.S. Food and Drug Administration or any other federal governmental body with authority to regulate the use of the technology.
  - ii. Any approval that is granted as an interim step in the U.S. Food and Drug Administration's or any other federal governmental body's regulatory process is not sufficient.
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes, as demonstrated by:
  - i. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.
  - ii. The evidence should demonstrate that the technology could measure

or alter the physiological changes related to a disease, injury, illness, or condition. In addition, there should be evidence or a convincing argument based on established medical facts that such measurement or alteration affects health outcomes.

- The technology must improve the net health outcome, as demonstrated by:
    i. The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.
- The improvement must be attainable outside the investigational settings, as demonstrated by:
    i. In reviewing the criteria above, the medical policy panel will consider physician specialty society recommendations, the view of prudent medical practitioners practicing in relevant clinical areas and any other relevant factors.

The Medical Director, in accordance with applicable ERISA standards, shall have discretionary authority 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 or 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-experimental or Investigational services, or
- the findings of the BlueCross BlueShield Association Technology Evaluation Center or other similar qualified evaluation entities.

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.

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

Maximum Allowable Charge - The amount that the administrator, at its discretion, has determined to be the maximum amount payable for a Covered Service. For Covered Services provided by Network Providers, that determination will be based upon the administrator's contract with the Network Provider for Covered Services rendered by that Provider. For Covered Services provided by Out-of-Network Providers, the amount payable will be based ~~on~~ upon the administrator's Out-of-Network fee schedule

for the Covered Services rendered by Out-of-Network Providers. For Out-of-Network Emergency Care Services, the Maximum Allowable Charge for a Covered Service complies with the Affordable Care Act requirement to be based upon the greater of (a) the median amount negotiated with Network providers for the Emergency Care Services furnished, (b) the amount for the Emergency Care Services calculated using the same method generally used to determine payments for Out-of-Network services, or (c) the amount that would be paid under Medicare for the Emergency Care Services.

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

Medically Appropriate – – Services that have been determined by BlueCross in its sole discretion to be of value in the care of a specific Member. To be Medically Appropriate, a service must meet all of the following:

- be Medically Necessary;
- be consistent with generally accepted standards of 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;
- not be provided solely to improve a Member's condition beyond normal variations in individual development, appearance and aging; and
- 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 BlueCross 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, which, at the time a Member receives Covered Services has an agreement with BlueCross (or entity contracting with BlueCross) to provide those health care services to Members under this plan. A Network Provider may bill or seek reimbursement for Authorized Services from BlueCross, except for the Member's Deductibles, Copayments, or Coinsurance amounts.

Network Provider - A Provider who has contracted with the administrator to provide Covered Services to Members at specified rates. Such Providers may be referred to as Blue Card PPO Participating Providers, participating hospitals, Transplant Network, etc. Some providers may have contracted with the administrator to provide a limited set of Covered Services, such as only Emergency Care Services, and are treated as Network Providers for this limited set of Covered Services.

Non-Contracted Provider – A Provider that renders Covered Services to a Member, in the situation where We have not contracted with that Provider type to provide those Covered Services. These Providers can change, as We contract with different Providers. A Provider's status as a Non-Contracted Provider, Network Provider, or Out-of-Network Provider can and does change. We reserve the right to change a Provider's status.

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;
- 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 BlueCross to furnish services and to accept BlueCross'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; except that this does not include 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 a non-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.

Penalty/Penalties –A reduction in benefit amounts paid by Us as a result of failure to comply with Plan requirements such as failing to obtain Prior Authorization for certain Covered Services shown in Attachment C, Schedule of Benefits, as requiring such Prior Authorization. The Penalty will be a reduction in the Plan payment for Covered Services.

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.

Prior 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, which 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 which primarily provides minimal, custodial, ambulatory, or part time care, nor
- a facility which 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.

Telehealth – Remote consultation that meets Medical Necessity criteria.

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 Medically 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.

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 37402-2555

The Subscriber Number shown on my identification card is:

_____

The "Effective Date" when my coverage begins is:

_____