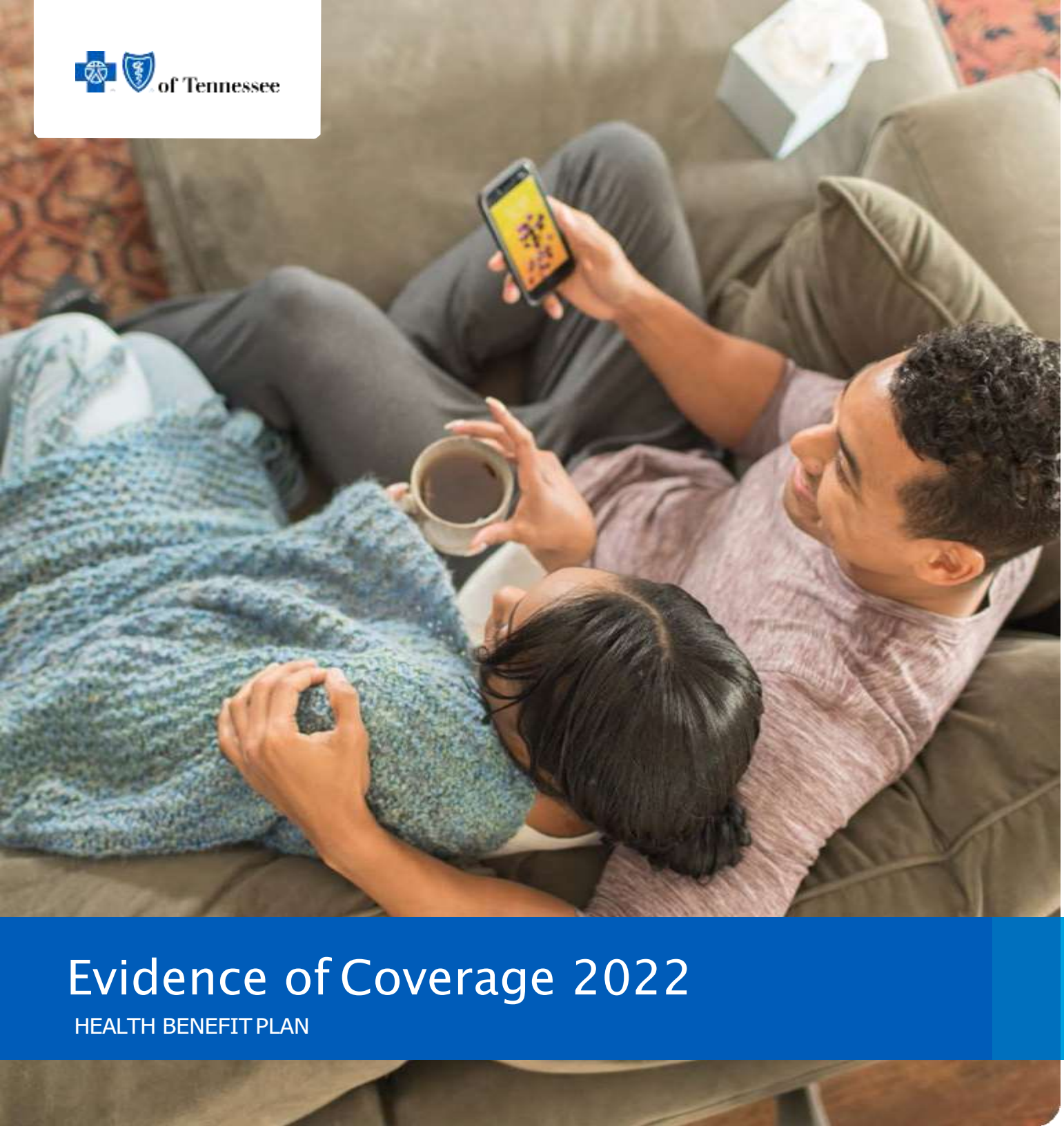
of Tennessee



Evidence of Coverage 2022

HEALTH BENEFIT PLAN

HAMILTON COUNTY DEPARTMENT OF EDUCATION
2022

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

Nondiscrimination Notice

BlueCross BlueShield of Tennessee (BlueCross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BlueCross does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

BlueCross:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified interpreters and (2) written information in other formats, such as large print, audio and accessible electronic formats.
- Provides free language services to people whose primary language is not English, such as: (1) qualified interpreters and (2) written information in other languages.

If you need these services, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711).

If you believe that BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance ("Nondiscrimination Grievance"). For help with preparing and submitting your Nondiscrimination Grievance, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711). They can provide you with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address your Nondiscrimination Grievance to: Nondiscrimination Compliance Coordinator; c/o Manager, Operations, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; (423) 591-9208 (fax); Nondiscrimination_OfficeGM@bcbst.com (email).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–368–1019, 800–537–7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-565-9140 (TTY: 1-800-848-0298).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-565-9140 (رقم هاتف الصم والبكم: 1-800-848-0298

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-565-9140 (TTY:1-800-848-0298)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
Gọi số 1-800-565-9140 (TTY:1-800-848-0298).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-565-9140 (TTY: 1-800-848-0298) 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-565-9140 (ATS : 1-800-848-0298).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-565-9140 (TTY: 1-800-848-0298).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-565-9140 (መስማት ለተሳናቸው: 1-800-848-0298).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-565-9140 (TTY: 1-800-848-0298).

સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-565-9140 (TTY:1-800-848-0298)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-565-9140 (TTY:1-800-848-0298) まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-565-9140 (TTY:1-800-848-0298).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-565-9140 (TTY:1-800-848-0298) पर कॉल करें।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-565-9140 (телетайп: 1-800-848-0298).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-565-9140 (TTY:1-800-848-0298) تماس بگیرید.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-565-9140 (TTY: 1-800-848-0298).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-565-9140 (TTY: 1-800-848-0298).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-565-9140 (TTY: 1-800-848-0298).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-565-9140 (TTY: 1-800-848-0298).

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-565-9140 (TTY: 1-800-848-0298).

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:

CONSUMER ADVISORS
BLUECROSS BLUESHIELD OF TENNESSEE, INC.,
ADMINISTRATOR
1 CAMERON HILL CIRCLE
CHATTANOOGA, TENNESSEE 37402
(800) 565-9140

TABLE OF CONTENTS

INTRODUCTION

This Evidence of Coverage (this "EOC") was created for the Employer (listed on the cover of this EOC) as part of its Employee welfare benefit 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. The 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, the Plan Administrator or the Plan Fiduciary, as those terms are defined in ERISA. The Employer is the Plan Fiduciary, the Plan Sponsor and the Plan Administrator. These ERISA terms are used in this EOC to clarify their meaning, even though the Plan is not subject to ERISA. Other federal laws may also affect Your Coverage. To the extent applicable, the Plan complies with federal requirements.

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

PLEASE READ THIS EOC CAREFULLY. IT DESCRIBES THE RIGHTS AND DUTIES OF MEMBERS. IT IS IMPORTANT TO READ THE ENTIRE EOC. CERTAIN SERVICES ARE NOT COVERED BY THE PLAN. OTHER COVERED SERVICES ARE OR MAY BE LIMITED. THE PLAN WILL NOT PAY FOR ANY SERVICE NOT SPECIFICALLY LISTED AS A COVERED SERVICE, EVEN IF A HEALTH CARE PROVIDER RECOMMENDS OR ORDERS THAT NON-COVERED SERVICE.

Employer has delegated discretionary authority to make any benefit determinations to the administrator; the Employer also has the authority to make any final Plan determination. The Employer, as the Plan Administrator, and BlueCross also have the authority to construe the terms of Your Coverage. The Plan and BlueCross shall be deemed to have properly exercised that authority unless it abuses its discretion when making such determinations, whether or not the Employer's benefit plan is subject to ERISA. 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 consumer advisors, at the number listed on the Subscriber's membership ID card, if You have any questions when reading this EOC. The consumer advisors are also available to discuss any other matters related to Your Coverage from the Plan.

INDEPENDENT LICENSEE OF THE BLUECROSS BLUESHIELD ASSOCIATION

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 independent contractors and are not Employees, agents or representatives of the administrator. Network 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 determinations and interpret the terms of Your Coverage, the Employer, as the Plan Administrator as that term is defined in ERISA, has the discretionary authority to make the final determination regarding the terms of Your Coverage ("Coverage Decisions"). Both the administrator and the Employer make Coverage Decisions based on the terms of this EOC, the ASA, and applicable State or Federal laws. The Employer retains the authority to determine whether You or Your dependents are eligible for Coverage.

You may request reconsideration of that a Coverage 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.

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.

REWARDS OR INCENTIVES

Any reward or incentive You receive under a health or wellness program may be taxable. Talk to Your tax advisor for guidance. Rewards or incentives may include cash or cash equivalents, merchandise, gift cards, debit cards, Premium discounts or rebates, contributions toward Your health savings account (if applicable), or modifications to a co-payment, co-insurance, or deductible amount.

OUR PAYMENT METHODS FOR NETWORK PROVIDERS

Our agreements with Network Providers include different payment arrangements. We use various alternative Provider payment methodologies including, but not limited to, Diagnosis Related Group (DRG) payments, discounted fee-for-service payments, patient-centered medical home programs, bundled payments for episodes of care, pay-for-performance initiatives, and other quality improvement and/or cost containment programs.

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 Employer's Human Resources Department You change:

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

Subscribers must notify the Employer's Benefits Department of any eligibility or status changes for themselves or Covered Dependents, including:

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

Group Number: 81009

Annual Benefit Period: January 1, 2022, to December 31, 2022

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 the Subscriber's membership ID card before services are provided. Otherwise, Your benefits may be reduced or denied.

For the following services rendered by an Out-of-Network Provider, Network Benefits including Deductible and Out-of-Pocket Maximum will apply, and the Provider may not balance bill You as required by state or federal law:

1. Emergency Care Services rendered at an out-of-network hospital, when considered a true Emergency.

2. Items and services rendered by an Out-of-Network Provider at an in-network hospital. Note that in certain circumstances, You may agree to receive treatment from an Out-of-Network Provider and waive balance billing protections, provided that You provide consent prior to treatment, and that Your consent satisfies applicable regulatory requirements.

3. Emergent and other Authorized air ambulance services (the same criteria to determine if services from an in-network air ambulance Provider are Covered is used to determine whether services from an out-of-network air ambulance Provider is Covered).

Also, if You are seeing a Network Provider that becomes an Out-of-Network Provider and You have complex care or other needs as defined by state or federal law, You are eligible for Network Benefits for 120 days, giving You the opportunity to find a Network Provider to receive a Network Benefit in the future. Please contact Our consumer advisors at the Member Service

number on the back of Your ID card if You would like to request Network Benefits from an Out-of-Network Provider.

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

Covered Services	In-Network Benefits for Covered Services received from Network Providers (1)	Out-of-Network Benefits for Covered Services received from Out-of-Network Providers (2)
Services Received at the Practitioner's Office		
Office Exams and Consultations		
Diagnosis and treatment of injury or illness, including medical and behavioral health conditions	90% after Deductible	70% of the Maximum Allowable Charge after Deductible
Maternity office visits	90% after Deductible	70% of the Maximum Allowable Charge after Deductible
Preventive & Wellcare Exams and Immunizations - Children & Adults Includes Preventive Health Exam, screenings and counseling services. Tobacco use counseling performed in a primary care setting, limited to 8 visits per Annual Benefit Period; Alcohol misuse counseling performed in a primary care setting, limited to 8 visits per Annual Benefit Period; Dietary counseling for adults with hyperlipidemia, hypertension, obesity, Type 2 diabetes, coronary artery disease and/or congestive heart failure limited to 12 visits annually.	100%	70% of the Maximum Allowable Charge
Allergy Injections	90% after Deductible	70% of the Maximum Allowable Charge after Deductible
All other injections	90% after Deductible	70% of the Maximum Allowable Charge after Deductible
Provider-administered Specialty Drugs	90% after Deductible	70% of the Maximum Allowable Charge after Deductible
Diagnostic Services (e.g. x-ray and labwork)		
Allergy Testing	90% after Deductible	70% of the Maximum Allowable Charge after Deductible
Routine Diagnostic Services for illness or injury	90% after Deductible	70% of the Maximum Allowable Charge after Deductible

Covered Services	In-Network Benefits for Covered Services received from Network Providers (1)	Out-of-Network Benefits for Covered Services received from Out-of-Network Providers (2)
Non Routine Diagnostics Services (3)	90% after Deductible	70% of the Maximum Allowable Charge after Deductible
Maternity care diagnostic services	90% after Deductible	70% of the Maximum Allowable Charge after Deductible
Preventive Screenings – Children & Adults	100%	70% of the Maximum Allowable Charge
Preventive Mammogram, Cervical Cancer Screening and Prostate Screening	100%	70% of the Maximum Allowable Charge
Lactation counseling by a trained provider during pregnancy or in the post-partum period. Limited to one visit per pregnancy.	100%	70% of the Maximum Allowable Charge
Manual Breast Pump, limited to one per pregnancy	100%	70% of the Maximum Allowable Charge
FDA-approved contraceptive methods, sterilization procedures and counseling for women with reproductive capacity.	100%	70% of the Maximum Allowable Charge
One (1) retinopathy screening for diabetics per Annual Benefit Period	100%	Not Covered
Hemoglobin A1C	100%	70% of the Maximum Allowable Charge
Other office procedures, services or supplies		
Office Surgery, including anesthesia (5), (6)	90%	70% of the Maximum Allowable Charge
Therapy Services: Physical, speech, occupational and manipulative; cardiac and pulmonary rehab	90% after Deductible	70% of the Maximum Allowable Charge after Deductible
DME, Orthotics and Prosthetics (10)	90% after Deductible	70% of the Maximum Allowable Charge after Deductible
Supplies	90% after Deductible	70% of the Maximum Allowable Charge after Deductible
All Other Office Services	90% after Deductible	70% of the Maximum Allowable Charge after Deductible
Services Received at a Facility		
Inpatient Hospital Stays, Behavioral Health Services, and Inpatient Hospice Care (4)	90% after Deductible	70% of the Maximum Allowable Charge after Deductible
Skilled Nursing or Rehab Facility stays (4)	100%	70% of the Maximum Allowable Charge after Deductible

Covered Services	In-Network Benefits for Covered Services received from Network Providers (1)	Out-of-Network Benefits for Covered Services received from Out-of-Network Providers (2)
Emergency Care Services (Whether the Practitioner is considered an Emergency physician and therefore reimbursable under this benefit is determined by the place of service on the claim.)	90% after Deductible	90% of the Maximum Allowable Charge after Deductible
Emergency Room charges	90% after Deductible	90% of the Maximum Allowable Charge after Deductible
Outpatient Routine Diagnostic Services	90%	70% of the Maximum Allowable Charge after Deductible
Outpatient Surgery	90%	70% of the Maximum Allowable Charge
Non-Routine Diagnostic Services (3)	90% after Deductible	70% of the Maximum Allowable Charge after Deductible
All Other Hospital charges	90% after Deductible	70% of the Maximum Allowable Charge after Deductible
Other Outpatient procedures, services, or supplies		
Therapy Services: Physical, speech, occupational, and manipulative; Cardiac and pulmonary rehab	90% after Deductible	70% of the Maximum Allowable Charge after Deductible
DME, Orthotics, and Prosthetics (10)	90% after Deductible	70% of the Maximum Allowable Charge after Deductible
All other services received at an Outpatient Facility, including chemotherapy, radiation therapy, injections, infusions, and dialysis	90% after Deductible	70% of the Maximum Allowable Charge after Deductible
Other Services		
Urgent Care Center	90% after Deductible	70% of the Maximum Allowable Charge after Deductible
Ground Ambulance	90% of Billed Charges after Deductible	90% of Billed Charges after Deductible
Air Ambulance	90% after Deductible	90% of the Maximum Allowable Charge after Deductible
Home health care services (7)	100%	70% of the Maximum Allowable Charge after Deductible
Home Infusion Therapy (7)	90% after Deductible	70% of the Maximum Allowable Charge after Deductible

Covered Services	In-Network Benefits for Covered Services received from Network Providers [1]		Out-of-Network Benefits for Covered Services received from Out-of-Network Providers [2]
Outpatient Hospice Care - In Home [7]	100%		70% of the Maximum Allowable Charge
Hospice Care - Inpatient [7]	90% after Deductible		70% of the Maximum Allowable Charge after Deductible
Hearing Aids for Members under age 18 limited to one per ear every 3 Annual Benefit Periods	90% after Deductible		70% of the Maximum Allowable Charge after Deductible
Vision Care – 1 vision exam per Annual Benefit Period	90% after Deductible		70% of the Maximum Allowable Charge after Deductible
Medical Vision Care			
Vision exam for the treatment of injuries and diseases of the eye	90% after Deductible		70% of the Maximum Allowable Charge after Deductible
Frames, lenses, and contacts Covered following treatment and surgery to repair certain injuries and diseases that impair vision	90% after Deductible		70% of the Maximum Allowable Charge after Deductible
Organ Transplant Services			
Transplant Services	**Blue Distinction Centers for Transplants (BDCT) Network**: 90% after Network Deductible, Network Out-of-Pocket Maximum applies.	**Transplant Network:** 90% after Network Deductible, Network Out-of-Pocket Maximum applies.	**Out-of-Network Providers**: 70% of the Maximum Allowable Charge, after Out-of-Network Deductible, Out-of-Network Out-of-Pocket Maximum applies.
Network Providers not in Our Transplant Network include Network Providers in Tennessee and BlueCard PPO Providers outside Tennessee.			

Schedule of Pharmacy Prescription Drug Copayments

	One month supply (Up to 30 days)	Three months' supply (90 days)
Generic Drug/Preferred Brand Drug/Non-Preferred Brand Drug		
Retail Network	$5/$20/$30	N/A
Mail Order Network	$5/$20/$30	$5/$20/$30
Plus90 Network	$5/$20/$30	$5/$20/$30
Onsite Pharmacy	$0/$10/$20	$0/$10/$20
Out-of-Network	Not Covered.	

Self-administered Specialty Drugs - You have a distinct network for self-administered Specialty Drugs: the Preferred Specialty Pharmacy Network. To receive benefits for self-administered Specialty Drugs, You must use a Preferred Specialty Pharmacy Network Provider. For more information on benefits for Provider-administered Specialty Drugs, please refer to the "Specialty Drugs" section of this EOC.

Limited up to a 30-day supply per Prescription

Specialty Pharmacy Network - Preferred	$5/$20/$30 Drug Copayment per Prescription
Out-of-Network	Not Covered

Additional Provisions

90 day supplies are available through the Mail Order Network and the Plus90 Network. See bcbst.com to locate network pharmacies and to learn more about the Mail Order Network.

At the Network Pharmacy, You will pay the lesser of Your applicable Copayment Coinsurance, or the Maximum Allowable Charge. Our discounted rate or the Network Pharmacy's charge for the Prescription Drug.

For both Prescription Drugs and self-administered Specialty Drugs, if You choose a Preferred Brand Drug, or Non-Preferred Brand Drug when a Generic Drug equivalent is available, You will be financially responsible for the Generic Drug Copay or Coinsurance plus a Penalty. The Penalty is the difference between the cost of the Preferred Brand Drug or Non-Preferred Brand Drug and the Generic Drug. You may request an exception by completing the Pharmaceutical Exception Request form available on Our website at bcbst.com.

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 out-of-network Deductible, Coinsurance, and/or Drug Copayment amount.

In the Self-administered Specialty Drugs section, Out-of-Network refers to outside the Specialty Pharmacy Network, not outside the standard retail Pharmacy Network.

Miscellaneous Limits		
Lifetime Maximum	Unlimited	
Dependent Age Limit	To Age 26	
Deductible [11] [12] Individual Family	 $450 $1,200	 $800 $2,400
4th Quarter Deductible Carryover	Yes	

Out-of-Pocket Maximum Individual Family	 $1,750 $4,750	 $3,000 $9,000

1. Benefit percentages apply to BlueCross Maximum Allowable Charge. In-Network level applies to services received from Network Providers and Non-Contracted Providers. Member may be responsible for any amount exceeding Maximum Allowable Charge for services received from Non-Contracted Providers.
2. Out-of-Network benefit percentages apply to BlueCross Maximum Allowable Charge. Member may be responsible for any amount exceeding the Maximum Allowable Charge for services received from Out-of-Network Providers.
3. Non-Routine Diagnostic services including CT scans, MRIs, PET scans, nuclear medicine and other similar technologies require a prior authorization. If an authorization is not obtained and services are deemed Medically Necessary then benefits may be reduced to 50% of the Maximum Allowable Charge subject to the Deductible.
4. Inpatient hospital stays (except initial maternity admission and Emergency admissions) and Behavioral Health Services require a Prior Authorization.
5. Some procedures require Prior Authorization. Call Our consumer advisors to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, benefits may be reduced to 50% for Out-of-Network Providers and to 50% for Network Providers outside Tennessee (BlueCard PPO Providers) when Prior Authorization is not obtained. (See the Prior Authorization section for more information.) Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization..
6. Surgeries include invasive diagnostic services (e.g., colonoscopy, sigmoidoscopy).
7. Prior Authorization required.
8. All Transplant Services require Prior Authorization. Call Our consumer advisors before any pre-transplant evaluation or other transplant service is performed to request Prior Authorization, and to determine if there are facilities available in the BDCT Network for Your specific transplant type. See the "Prior Authorization, Care Management, Medical Policy and Patient Safety" and "Organ Transplants" sections of this EOC for more information.
9. Network Providers not in our Transplant Network include Network Providers in Tennessee and BlueCard PPO Providers outside Tennessee.
10. Prior Authorization required for Prosthetics, Orthotics, and certain Durable Medical Equipment (DME).
11. The Deductible will be waived for accidental injuries.
12. If a Member has Covered Charges during the last three months of an Annual Benefit Period that are applied to that year's Deductible, these charges will also be applied toward the Deductible for the next year.

ADDITIONAL BENEFITS

Blood or blood plasma, including components and derivatives, will be an eligible expense when provided by a Hospital. This is not an eligible expense if blood is donated or replaced.

The Deductible will not apply to the following services for In Network Providers:

- Outpatient Surgery and related expenses performed on same day of surgery
- Outpatient Diagnostic X-ray and laboratory Exams
- Second Surgical Opinion Consultation Expenses within three months of the first opinion
- Preventive Services
- Pre-admission Testing

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

- Outpatient Hospice Care
- Home Health Care Agency Expenses
- Convalescent Care (Benefits will be available after five (5) consecutive days of hospitalization.

Benefits are available for Radial Keratotomy (RK) (corrective vision surgery).

Benefits are available at 100% for Travel Expenses (travel, meals, and lodging) to and from the site for one family Member to accompany a patient (minor or adult) who is traveling more than 50 miles for treatments/services that are not available within the Hamilton County area. The aggregate limit for all Travel Expenses is $25,000 per Annual Benefit Period.

CARDIAC REHABILITATION SERVICES

Benefits are available for procedures for Phase I and Phase II of Cardiac Rehabilitation Services, including:

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

Services must be completed within 6 months 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 medical facility in accordance with Medical Necessity guidelines with regard to the frequency and duration of exercise and education programs.

DRUGS – PRESCRIPTION COVERAGE

Medically Necessary and Medically Appropriate Prescription Drugs for the treatment of disease or injury. Covered Prescription Drugs are identified on the Drug Formulary, which can be found at bcbst.com.

1. Covered Services

a. Certain Prescription Drugs are Covered at 100% at Network Pharmacies, in accordance with the Preventive Services provision of the Affordable Care Act and are identified on the Drug Formulary with an "ACA" indicator.

Prescription Drugs on the Drug Formulary that do not have an "ACA" indicator are Covered at the standard Prescription Drug benefits listed in "Attachment C: Schedule of Benefits."

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

   – dispensed by a licensed pharmacist or dispensing Practitioner on or after the date Your Coverage begins;

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

   – listed on the Drug Formulary.

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

d. As prescribed for the treatment of diabetes: blood glucose monitors, including monitors designed for the legally blind; test strips for glucose monitoring; visual reading and urine test strips; insulin; injection aids; syringes; lancets; oral hypoglycemic agents; glucagon emergency kits; and injectable incretin mimetics when used in conjunction with selected Prescription Drugs for the treatment of diabetes.

e. Immunizations administered at a Network Pharmacy.

f. Drugs, dietary supplements and vitamins with a Prescription that are listed with an A or B recommendation by the United States Preventive Services Task Force (USPSTF) in accordance with federal regulations.

g. Certain drugs require Step Therapy. 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.

h. Compound Drugs are Covered only when filled at a Network Pharmacy. The Network Pharmacy must submit the claim through the Administrator's Pharmacy benefit manager. The claim must contain a valid national drug code (NDC) number for all ingredients in the Compound Drug. The Compound Drug claim will apply the Non-Preferred Brand Drug Copayment. Prior Authorization may be required for certain Compound Drugs.

i. Prescription Drugs that are commercially packaged or commonly dispensed in quantities less than a 30-calendar day supply (e.g. Prescription Drugs 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.

j. Prescription and over-the-counter (OTC) nicotine replacement therapy and aids to smoking cessation including, but not limited to, patches;

k. any Prescription Drugs or medications used for the treatment of sexual dysfunction, including but not limited to erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido;

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.

2. **Exclusions**

a. Prescription Drugs not on the Drug Formulary;

b. drugs that are prescribed, dispensed or intended for use while You are confined in a hospital, skilled nursing facility or similar facility, except as otherwise stated in this EOC;

c. Prescription Drugs dispensed in a doctor's office except as otherwise Covered in the EOC;

d. any Prescription Drugs that exceed Quantity Limits specified by the Administrator's P & T Committee;

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

f. any Prescription Drug dispensed by or through a non-retail Internet Pharmacy;

g. medications intended to terminate a pregnancy;

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

i. artificial appliances;

j. allergen extracts;

k. any Prescription Drugs dispensed more than one year following the date of the original Prescription, unless otherwise specified by Tennessee state or federal law;

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

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

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

o. Prescription Drugs used for the treatment of infertility;

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. 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;

t. drugs used to enhance athletic performance;

u. Experimental and/or Investigational Drugs;

v. Prescription Drugs or refills dispensed:

- in quantities in excess of amounts specified in the Benefit payment section;

- without Our Prior Authorization when required; or
- that exceed any applicable Annual Maximum Benefit, or any other maximum benefit amounts stated in the EOC.

w. contraceptives that require administration or insertion by a Provider (e.g., non-drug devices, implantable products such as Norplant, except injectables), except as otherwise Covered in the EOC;

x. 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.

y. 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.

z. Any drugs, medications, Prescription devices, dietary supplements or vitamins available over-the-counter without a Prescription, except as required by Tennessee or federal law.

aa. Prescription refills requested outside the Plan's time limits. If You request a refill too soon, the Network Pharmacy will advise You when Your Prescription Drug benefit will Cover the refill.

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

The drug lists referenced in this section are subject to change. Current lists can be found at bcbst.com, or by calling the number on the back of Your Member ID card.

bb. Compound Drugs made from bulk powders, chemicals and kits, unless Medically Necessary and Medically Appropriate.

cc. Drugs used for substance use disorder administered or dispensed directly by a Practitioner.

SPECIALTY DRUGS

Medically Necessary and Medically Appropriate Specialty Drugs used to treat chronic, complex conditions and that typically require special handling, administration or monitoring. Prior Authorization is required for certain Specialty Drugs; if Prior Authorization is not obtained, benefits will be reduced. Call the Administrator's consumer advisors at the number listed on the back of Your Member ID card or check bcbst.com to find out which Specialty Drugs require Prior Authorization.

1. Covered Services
   a. Provider-administered Specialty Drugs as identified on the Provider-administered Specialty Drug list. The current list can be found at bcbst.com or by calling the number on the back of Your ID card.
   b. Self-administered Specialty Drugs as identified on the Drug Formulary when dispensed by a Pharmacy in Our Specialty Pharmacy Network, which can be found at bcbst.com or by calling the number on the back of Your ID card.
2. Exclusions
   a. Self-administered Specialty Drugs that are not dispensed by a Pharmacy in Our Specialty Pharmacy Network.
   b. FDA-approved drugs used for purposes other than those approved by the FDA, unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia.

SECTION I - ELIGIBILITY

COVERAGE FOR YOU

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

COVERAGE FOR YOUR DEPENDENTS

If the Subscriber is covered by this Plan, he or she may enroll Eligible Dependents. The Subscriber and his or her Covered Dependents are also called Members. The names, dates of birth and Social Security numbers 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. Dependents may only be covered on this plan after providing proof of eligibility. For children, proof of eligibility includes both a Social Security number and a birth certificate. For spouses, proof of eligibility includes both a Social Security number, a marriage certificate and a completed spousal coverage affidavit. Additional proof of eligibility will be required for foster and adopted children, as well as custodial arrangements.

TYPES OF COVERAGE AVAILABLE

Individual - Employee only

Two-Person - Employee and spouse

Employee/Child(ren) - Employee and child(ren) only, does not include coverage for a spouse

Family - Employee and all eligible Dependents

ELIGIBLE EMPLOYEES

To be eligible for coverage an Employee must be scheduled to work at least 30 hours per week. (Bus Drivers are eligible if scheduled to work 27½ hours per week.)

- Certified Active Employees
- Non-Certified Active Employees
- Food Service Active Employees
- Full-time Grandfathered Contract Bus Drivers
- Board Members

Eligible employees shall not include retired, seasonal, contract or temporary employees except for retirees that qualify to participate in Hamilton County Department of Education's Postretirement Health plan or qualify to participate in the health plan as a COBRA beneficiary.

The Plan has an Eligibility Waiting Period. Each Certificated and Classified Employee must wait until the first of the month following 60 days after he or she starts work before he or she is eligible for Coverage.

CHANGING COVERAGE

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

To make a change, the Subscriber should: (1) tell the Employer, and (2) apply for any needed change within 30 days of the change in family status, date the new Dependent is acquired, etc. For newborn Coverage, the Subscriber should apply within 60 days.

Changes in coverage will begin on the next Effective Date BlueCross bills the employer for this coverage (normally the first day of the month). Coverage for new Dependents added begins on the date the Dependent is acquired if the application is received within 30 days (60 days for newborns) after that date.

Surviving Dependents will be Covered until the last day of the month of Subscriber's death.

EFFECTIVE DATE

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

If the Employee has met the eligibility requirements and the Employee and his or her Eligible Dependents apply when first eligible (or within 30 days), coverage will be effective on the next Effective Date BlueCross bills the Employer.

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

APPLYING FOR COVERAGE

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

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

a. The Subscriber's current spouse as recognized by Tennessee law; or

b. The 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. 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 Subscriber or Subscriber's spouse.

Employer requires a spousal affidavit that must be filled out by any Employee covering a spouse for medical coverage. If a spouse has access to his or her own employer-sponsored group coverage, he or she cannot be covered under the HCDE plan. If the spouse does not have access to employer-sponsored coverage or does not work, then the HCDE employee can add/keep the spouse on the plan for an additional amount per month added to the cost of coverage. Contact the Employer's Benefits Department at (423) 209-8566 for questions regarding the spousal affidavit and premiums.

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

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

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

Changes in coverage will begin on the next Effective Date BlueCross bills the employer for this coverage (normally the first day of the month). Coverage for new Dependents added begins on the date the Dependent is acquired if the application is received within 30 days after that date. For newborns, the application should be received within 60 days.

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 30 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) change in dependency status; (4) Medicare eligibility; (5) coverage by another Payor; (6) birth or adoption of a child of the Employee; (7) termination of employment, or commencement of employment, of the 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) taking an unpaid leave of absence by the Subscriber or the Subscriber's spouse, 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.

BECOMING COVERED

ELIGIBILITY, ENROLLMENT, AND EFFECTIVE DATE

You are a member of the class eligible for the coverage described in this booklet if you are a regular, full-time employee of the group policyholder scheduled to work at least thirty hours per week (Bus Drivers are eligible if scheduled to work 27 ½ hours per week), or if you belong in one of the categories listed below.

- Employees on paid or unpaid leave of absence approved by the Board when they continue uninterrupted coverage.
- Retired Employees who are retired receiving a pension benefit from the group policyholder after attaining the required age and/or completing the required years of service. Eligibility for retirees ceases at age 65 or when eligible for Medicare. Eligibility for the spouse of a retiree ceases when the spouse reaches age 65 or when the spouse becomes eligible for Medicare. See the Retirement Health Plan Document or contact your benefits department for complete information on Retiree benefits.
- Disabled Employees may continue coverage as long as they continue to meet the definition of disability and are receiving long-term disability benefits. These Members may be required to pay the full cost of coverage.

All members of the class eligible for coverage are required to pay premiums for coverage. Benefits will not be paid until you are enrolled in the Plan.

Eligibility continues for school-term employees, who complete their contracted term and resign by June 30, until the last day of August or when the employee becomes eligible for any other group plan, whichever comes first.

The holder of an "Interim" or "Open" position ceases to be an employee and a member of the class eligible for insurance upon the expiration of his or her appointment. However, if the holder of an "Interim" or "Open" position is actively at work at the end of one school term and is rehired effective with the beginning of the next school term, this person will be considered actively at work on the date of board appointment for the next term.

Enrollment must occur when you are first eligible or during one of the optional enrollment periods described below. You are "first eligible" beginning the first day you are actively at work and ending thirty days thereafter or thirty days after the Board approval of employment if not longer.

If you enroll when first eligible, your coverage will be effective on first of the month following 60 days after you start work, except for a dependent hospitalized on that date, in which case that dependent would be covered on the day following discharge from the hospital. Coverage for non-bargaining employees will be effective on the 1st of the month following the 60th day of employment.

If you do not elect the coverage available to you or your spouse and dependents when first eligible, and you later decide to enroll or add coverage, you may do so during the Open Enrollment period during the month of October, or within thirty calendar days following marriage, divorce, documented loss of employment by spouse, or acquisition of an eligible dependent by means other than birth.

If you enroll or add coverage during the Open Enrollment period, your coverage or additional coverage will be effective on January 1st. If a dependent is hospitalized on that date he or she will not be covered until the day after discharge from the hospital. If the Employee has previously declined Individual Coverage, he or she must be actively at work on the effective date of coverage.

You should notify the Benefits Department immediately if there is an addition to or deletion from your list of eligible dependents. It may affect your type of coverage and premium or eliminate delays in claim payments.

SECTION II - INTER-PLAN ARRANGEMENTS

Out-of-Area Services

Overview

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever You access healthcare services outside the geographic area We serve, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When You receive care outside of Our service area, You will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some providers ("nonparticipating providers") don't contract with the Host Blue. We explain below how We pay both kinds of providers.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits except when paid as medical claims/benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by Us to provide the specific service or services.

A. BlueCard® Program

Under the BlueCard® Program, when You receive Covered Services within the geographic area served by a Host Blue, We will remain responsible for doing what We agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

When You receive Covered Services outside Our service area and the claim is processed through the BlueCard Program, the amount You pay for Covered Services is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to Us.

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 also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price We have used for Your claim because they will not be applied after a claim has already been paid.

B. Special Cases: Value-Based Programs

- *BlueCard® Program*
- If You receive Covered Services under a Value-Based Program inside a Host Blue's service area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Us through average pricing or fee schedule adjustments. Additional information is available upon request.
- *Value-Based Program Definitions*

  Accountable Care Organization (ACO): A group of healthcare providers who agree to deliver coordinated care and meet performance benchmarks for quality and affordability in order to manage the total cost of care for their member populations.

  Care Coordination: Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Member's healthcare needs across the continuum of care.

  Care Coordinator: An individual within a provider organization who facilitates Care Coordination for patients.

  Care Coordination Fee: A fixed amount paid by a Blue Cross and/or Blue Shield Licensee to providers periodically for Care Coordination under a Value-Based Program.

  Global Payment/Total Cost of Care: A payment methodology that is defined at the patient level and accounts for either all patient care or for a specific group of services delivered to the patient such as outpatient, physician, ancillary, hospital services and prescription drugs.

  Negotiated Arrangement, a.k.a., Negotiated National Account Arrangement: An agreement negotiated between a Control/Home Licensee and one or more Par/Host Licensees for any National Account that is not delivered through the BlueCard Program.

  Patient-Centered Medical Home (PCMH): A model of care in which each patient has an ongoing relationship with a primary care physician who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified physicians.

  Provider Incentive: An additional amount of compensation paid to a healthcare provider by a Blue Cross and/or Blue Shield Plan, based on the provider's compliance with agreed-upon procedural and/or outcome measures for a particular group of covered persons.

  Shared Savings: A payment mechanism in which the provider and payer share cost savings achieved against a target cost budget based upon agreed upon terms and may include downside risk.

  Value-Based Program (VBP): An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality

metrics/factors and is reflected in provider payment.

C. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to self-funded accounts. If applicable, BlueCross will include any such surcharge, tax or other fee as part of the claim charge passed on to You.

D. Nonparticipating Providers Outside Our Service Area

1. **Member Liability Calculation**

When Covered Services are provided outside of Our service area by nonparticipating providers, the amount You pay for such services will normally be based on either the Host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable law. In these situations, You may be responsible for the difference between the amount that the nonparticipating provider bills and the payment We will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

2. **Exceptions**

In certain situations, We may use other payment methods, such as billed charges for Covered Services, the payment We would make if the healthcare services had been obtained within Our service area, or a special negotiated payment to determine the amount We will pay for services provided by nonparticipating providers. In these situations, You may be liable for the difference between the amount that the nonparticipating provider bills and the payment We will make for the Covered Services as set forth in this paragraph.

E. Blue Cross Blue Shield Global® Core

If You are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), You may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists You with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when You receive care from providers outside the BlueCard service area, You will typically have to pay the providers and submit the claims Yourself to obtain reimbursement for these services.

If You need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, You should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

In most cases, if You contact the service center for assistance,

hospitals will not require You to pay for covered inpatient services, except for Your cost-share amounts. In such cases, the hospital will submit Your claims to the service center to begin claims processing. However, if You paid in full at the time of service, You must submit a claim to receive reimbursement for Covered Services. **You must contact Us to obtain precertification for non-emergency inpatient services.**

- **Outpatient Services**

  Physicians, Urgent Care Centers and other outpatient providers located outside the BlueCard service area will typically require You to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**

  When You pay for Covered Services outside the BlueCard service area, You must submit a claim to obtain reimbursement. For institutional and professional claims, You should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of Your claim. The claim form is available from Us, the service center or online at www.bcbsglobalcore.com. If You need assistance with Your claim submission, You should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

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, Care Management and specialty programs, such as transplant case management. BlueCross also provides Utilization Policies.

BlueCross does not make medical treatment decisions under any circumstances. You may always elect to receive services that do not comply with BlueCross' Care Management requirements or Utilization 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 Inpatient Hospice stays (except initial maternity admission and Emergency 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)
- Certain Advanced Radiological Imaging services
- Certain Prosthetics
- Certain Orthotics
- Certain Durable Medical Equipment (DME)
- Certain Air Ambulance Services

Notice of changes to the Prior Authorization list will be made via Our web site and the Member newsletter. For the most current list of services that require Prior Authorization, call our consumer advisors or visit Our web site at bcbst.com.

If You are receiving services from a Network Provider in Tennessee, and those services require a Prior Authorization the Network Provider is responsible for obtaining Prior Authorization. If the Network Provider fails to obtain Prior Authorization You are not responsible for any Penalty or reduction in benefits, unless You have signed a document agreeing to pay for the service regardless of Coverage.

If You are receiving Inpatient Facility services from a Network Provider outside of Tennessee, and those services require a Prior Authorization, the Network Provider is responsible for obtaining Prior Authorization. If the Network Provider fails to obtain Prior Authorization, You are not responsible for any Penalty or reduction in benefits, unless You have signed a document agreeing to pay for the service regardless of Coverage.

If You are receiving any services, other than Inpatient Facility services, from a Network Provider outside of Tennessee, and those services require a Prior Authorization, You are responsible for obtaining Prior Authorization. If You fail to obtain Prior Authorization, Your benefits may be reduced.

If You are receiving services from an Out-of-Network Provider, and those services require a Prior Authorization, You are responsible for obtaining Prior Authorization. If You fail to obtain Prior Authorization, Your benefits may be reduced.

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

B. Care Management

A number of Care Management programs are available to You across the care spectrum, including those with low-

risk health conditions and/or complicated medical needs.

Care Management personnel will work with You, Your family, Your doctors and other health care Providers to coordinate care, provide education and support and to identify the most appropriate care setting. Depending on the level of Care Management needed, Our personnel will maintain regular contact with You throughout treatment, coordinate clinical and health plan Coverage matters, and help You and Your family utilize available community resources.

After evaluation of Your condition, BlueCross may, at its discretion, determine that alternative treatment is Medically Necessary and Medically Appropriate.

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

Emerging Health Care Programs - Care Management is continually evaluating emerging health care programs. These are processes that demonstrate potential improvement in access, quality, efficiency, and Member satisfaction. When We approve an emerging health care program, approved services provided through that program are Covered, even though they may normally be excluded under this EOC.

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

C. Medical Policy

Medical Policy looks at the value of new and current medical science. Its goal is to make sure that Covered Services have proven medical value.

BlueCross medical policies address new and emerging medical technologies. 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. Visit bcbst.com/mpm to review Our medical policies. .

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

D. Patient Safety

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

HEALTH AND WELLNESS SERVICES

The Plan provides You with resources to help improve and manage Your health. To learn more about these resources, login at bcbst.com 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.

Digital Self-Guided Programs– Our interactive and educational digital self-guided programs help to inform You about common health and wellness 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.

Blue365® – The Blue365 Member discount program provides savings on a range of health-related products and services. For more information, log in at bcbst.com.

Fitness Your Way™ – Fitness Your Way is a discount fitness program that is intended to help You get and stay fit with a nationwide network of fitness facilities as well as live and recorded virtual fitness classes.

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 Utilization Policies may result in the denial of payment or a reduction in reimbursement for otherwise eligible Covered Services. Utilization Policies can help Your Provider determine if a proposed service will be Covered.

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. Only routine patient care associated with a Clinical Trial (but not the Clinical Trial itself) will be Covered under the Plan's benefits in accordance with Utilization Policies.

HOSPITAL AND OTHER FACILITY PROVIDER SERVICES

Inpatient Services

- Room, board, and general nursing care;
- 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);
- Certain therapy services; and
- Inpatient rehabilitative 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 Care Services

Benefits will be provided as specified in the Schedule of Benefits for Emergency Care 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 Care 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.

For Emergency Care Services, You cannot be billed for amounts over Your Deductible and Out-of-Pocket Maximum, even if the Covered Services are rendered by an Out-of-Network Provider.

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.

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
- Preventive/Well care services.

  Preventive health exam for adults and children in accordance with federal regulations, as outlined below and performed by the physician during the preventive health exam or referred by the physician as appropriate, including:

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

Diagnostic Services

Prior Authorization for Advanced Radiological Imaging must be obtained from the Plan, or benefits will be reduced or denied.

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

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

Maternity Services

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

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

OTHER SERVICES

Ambulance Services

Medically Necessary and Medically Appropriate ground or air transportation, services, supplies and medications by a licensed ambulance service when time or technical expertise is essential to reduce the probability of harm to You. Prior Authorization may be required for certain air ambulance services.

1. Covered Services
    a) Ambulance Services – Air
        1) Medically Necessary and Medically Appropriate air transportation from the scene of an accident or Emergency resulting in complex trauma, high risk injuries, or life-threatening medical emergencies to the nearest hospital with adequate facilities for evaluation and initial management. Air transportation is Covered only when Your condition requires immediate and rapid transport that cannot be provided by ground transport.
        2) Air transportation for inter-facility transfers when Medically Necessary treatment, services, or care are not available at the sending facility. The transfer must be to the nearest appropriate facility that is able to provide Medically Necessary care. Air transportation is Covered only when Your condition requires transport that cannot be provided by ground transport.
    b) Ambulance Services – Ground
        1) Medically Necessary and Medically Appropriate ground transportation from the scene of an accident or Emergency to the nearest hospital with adequate facilities for evaluation and management.
        2) Medically Necessary and Medically Appropriate treatment at the scene (paramedic services) without ambulance transportation.
        3) Medically Necessary and Medically Appropriate ground transport when Your condition requires basic or advanced life support, or safe transportation to site of service for the necessary level of care in the absence of appropriate alternatives.
2. Exclusions
    a) Transportation for the convenience of You or reasons other than Medically Necessary treatment and care for You, such as the needs or convenience of, Your family and/or Your physician or other Provider.
    b) Transportation that is not essential to reduce the probability of harm to You.
    c) Transportation for specific Provider or facility continuity of care when there are closer facilities able to provide the same services and level of care.

Urgent Care Center Services

Medically Necessary and Medically Appropriate treatment at an Urgent Care Center.

1. Covered Services
    a. Diagnosis and treatment of illness or injury.
    b. Diagnostic services (such as x-rays and laboratory services).
    c. Injections and medications administered in an Urgent Care Center, except Specialty Drugs. See the "Specialty Drugs" section for more information on Coverage.
    d. Surgery and supplies.
    e. Telehealth.
2. Exclusions
    a. Rehabilitative therapies in excess of the terms of this EOC.

Dental Care

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

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

Anesthesia for Dental Services

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

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

Diabetes Treatment

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

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

Services and supplies included under this provision shall include:

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

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

Durable Medical Equipment and Supplies

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

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

Eyeglasses or Contact Lenses

- routine refractive eye exam, one per Annual Benefit Period
- one set following cataract Surgery
- The first set of eyeglasses or contact lenses required to adjust for vision changes due to cataract Surgery and obtained within 6 months following the Surgery.
- One (1) retinopathy screening for diabetics per Annual Benefit Period.

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 Care

(Benefits are provided at 100%, not subject to the Deductible for outpatient Hospice Home Care. Benefits for inpatient Hospice care are provided at 90%, subject to the Deductible.)

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

In-home services are available, such as:

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

Office Visits for an Illness or Injury

Organ Transplants

Oran transplant benefits are complex. In order to maximize Your benefits, You are strongly encouraged to contact the Administrator's Transplant Case Management department by calling the number on the back of Your ID card as soon as Your Practitioner tells You that You might need a transplant.

1. Prior Authorization

   Transplant Services require Prior Authorization. Benefits for Transplant Services or supplies that have not received Prior Authorization will be reduced or denied.

2. Benefits

   Transplant benefits are different than benefits for other services.

   If a facility in the Blue Distinction Centers for Transplants (BDCT) Network is not used, benefits may be subject to reduced levels as outlined in Attachment C: Schedule of Benefits. All Transplant Services must meet medical criteria for which the transplant is recommended.

   You have access to three levels of benefits:

   a. **Blue Distinction Centers for Transplants (BDCT) Network:** If you have a transplant performed at a facility in the BDCT Network, You will receive the highest level of benefits for Covered Services. The administrator will pay at the benefit level listed in Attachment C: Schedule of Benefits for the BDCT Network. A facility in the BDCT Network cannot bill You for any amount over Your Out-of-Pocket Maximum, which limits Your liability. **Not all Network Providers are in the BDCT Network. Please check with Transplant Case Management to determine which facilities are in the BDCT Network for Your specific transplant type**.

   b. Transplant Network: If You want to receive the maximum benefit, You should use a facility in the BDCT Network. If You instead have a

transplant performed at a facility in the Transplant Network (non-BDCT), the Administrator will pay at the benefit level listed in "Attachment C: Schedule of Benefits" for the Transplant Network. Not all Network Providers are in the Transplant Network. Please check with the Transplant Case Management department to determine if the Transplant Network is the best network available for Your specific transplant type.

c. Out-of-Network transplants: If You have a transplant performed at a facility that is not in the BDCT Network or Transplant Network, You will receive the lowest level of benefits for Covered Services. The Administrator will pay at the benefit level listed in Attachment C: Schedule of Benefits for Out-of-Network Providers. The Out-of-Network Provider may bill you for any unpaid Billed Charges; this amount may be substantial. Please check with the Transplant Case Management department to determine if there are facilities available in the BDCT or Transplant Network for Your specific transplant type.

d. Note: When the BDCT Network does not include a facility that performs Your specific transplant type, the Plan will pay at the benefit level listed in "Attachment C: Schedule of Benefits" for either the Transplant Network or for Out-of-Network Provider, based on the facility that is used.

3. Covered Services

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

- Pancreas
- Pancreas/Kidney
- Kidney
- 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 Investigational and that are Medically Necessary and Medically Appropriate.

4. Organ and Tissue Procurement

Organ and tissue acquisition/procurement are Covered Services, subject to the benefit level listed in "Attachment C: Schedule of Benefits" and limited to the services directly related to the Transplant 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 directly related to the organ donation, except as otherwise indicated under Exclusions

Note: Covered Services for the donor are Covered only to the extent not covered by other health coverage.

5. Travel Expenses for Transplant Recipients

Travel Expenses for Transplant Services are Covered only if you go to a facility in the BDCT Network.

Covered travel and lodging expenses must be approved by Transplant Case Management and include travel to and from the facility in the BDCT Network for a Covered transplant procedure and required post-transplant follow-up. Any travel expenses for follow-up visits occurring more than 12 months from the date of the transplant are not Covered.

Covered travel expenses will not apply to the Deductible or Out-of-Pocket Maximum.

Meals and lodging expenses are Covered up to $150 per day, subject to the following:

- Lodging expenses are limited to $50 per person per day
- Meals are only Covered when provided at the facility where You are receiving inpatient medical care.
- The aggregate limit for travel expenses, including meals and lodging, is $10,000 per Covered transplant.

For full details on available travel expenses, visit bcbst.com to review Our administrative services policy. Enter "travel, meals and lodging" in the Search field.

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

c. Non-Covered Services;

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

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

f. 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;

g. 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;

h. 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;

i. 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.

j. Complications, side effects or injuries for the organ donor as a result of organ donation.

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.

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.

Hearing Aids

Medically Necessary and Medically Appropriate Hearing Aids used to enhance hearing when sustained loss is due to (1) birth defect; (2) accident; (3) illness; or (4) Surgery. Cochlear implants are not considered Hearing Aids.

Covered Services

a. The initial purchase of Covered Hearing Aids for Members under age 18, limited as indicated in "Attachment C: Schedule of Benefits."
The repair, adjustment or replacement of components and accessories necessary for the effective functioning of Covered equipment, except as otherwise indicated under Exclusions.

Exclusions

a. Hearing Aids for Members age 18 or older.

b. Hearing Aid batteries, cords and other assistive listening devices such as FM systems.

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

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

Family Planning and Reproductive Services

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

1. Covered Services

   a. Benefits for family planning, history, physical examination, diagnostic testing and genetic testing.

   a. Sterilization procedures.

   b. Services or supplies for infertility evaluation and testing.

   c. Medically Necessary and Medically Appropriate termination of a pregnancy.

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

2. Exclusions

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

   b. Services or supplies for the reversals of sterilizations.

   c. Induced abortion. Abortion will only be Covered if 1) the health care practitioner certifies in writing that the pregnancy would endanger the life of the mother; 2) the pregnancy is a result of rape or incest; 3) the fetus is not viable; 4) the fetus has been diagnosed with a lethal or otherwise significant abnormality.

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 that are not Medically Necessary
3. services provided before the Member's coverage begins
4. a drug, device, or medical treatment or procedure which is experimental or Investigational (see Section XII, 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 BlueCross or BlueShield group health plan, other health insurance plan, union welfare plan, or labor-management trust plan
14. Personal, physical fitness, recreational and convenience items, equipment and services, even if ordered by a licensed Practitioner, including, but not limited to: (1) barber and beauty services; (2) televisions; (3) air conditioners; (4) humidifiers; (5) air filters; (6) heaters, (7) saunas; (8) whirlpools; (9) water purifiers; (10) swimming pools; (11) tanning beds; (12) weight loss programs and exercise programs; or (13) self-help devices, programs or applications (including but not limited to mobile medical applications) of any type, whether for medical, behavioral health or non-medical use, unless such mobile application is approved in advance by BlueCross to be used in connection with a wellness program offered by BlueCross

15. charges for telephone consultations, e-mail or web based consultations, except as otherwise stated in this EOC

16. charges incurred due to failure to keep a scheduled appointment, or charges to complete a claim form or to provide medical records

17. Hospital admissions that are primarily for diagnostic studies

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. services or supplies for dental care, except as specified

22. eyeglasses, contact lenses, and examinations for and the fitting of eyeglasses and contact lenses

23. hearing aids and examinations for and the fitting of hearing aids, except as otherwise specified;

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

24. Hospital admissions primarily for physical therapy

    (Physical therapy is covered where there is another primary diagnosis.)

25. rehabilitative services not specifically listed as a Covered Service in Section IV

    (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 that may be covered under this provision include:

    - treatment to correct a previous tubal pregnancy, and
    - treatment by ovulatory drugs (such as clomid) or hormonal treatment used primarily to treat irregular menstrual periods.

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, unless otherwise specified (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 Covered Services

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 health plan, 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 that consist primarily of behavior modification, diet and weight monitoring, and educational services

38. Services or supplies, including bariatric Surgery, for weight loss or to treat obesity, even if You have other health conditions that might be helped by weight loss or reduction of obesity. This exclusion applies whether You are of normal weight, overweight, obese or morbidly obese

39. any charges for services and supplies rendered to a Member that require the Prior Authorization of BlueCross BlueShield of Tennessee, where such Prior Authorization is not given

40. services or supplies rendered prior to the Effective Date or after a Member's coverage is terminated, except as otherwise specified

41. room, board, and general nursing care rendered on the date of discharge, unless both admission and discharge occur on the same day

42. 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

43. staff consultations required by Hospital rules

44. 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

45. 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

46. 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

47. Inpatient private duty nursing in an acute care Hospital

48. prescription drugs, over-the-counter drugs (not requiring a prescription), unless required by law or specifically designated as covered under this Plan; prescription devices, vitamins, except those that by law require a prescription; and/or prescription drugs dispensed in a doctor's office

49. for any care or treatment involving acupuncture

50. replacement of implanted cataract lenses

51. for court-ordered treatment of a Subscriber unless benefits are otherwise payable

52. medical treatment for which the Member has been reimbursed under a mass tort or class action lawsuit, settlement or judgment

53. Services considered Cosmetic, except when Medically Necessary and Medically Appropriate. This exclusion also applies to Surgeries to improve appearance following a prior Surgical Procedure, even if that prior procedure was a Covered Service. Services that could be considered Cosmetic include, but are not limited to: (1) breast augmentation; (2) sclerotherapy injections, laser or other treatment of spider veins and varicose veins; (3) rhinoplasty; (4) panniculectomy/abdominoplasty;; and (5) Botulinum toxin

54. Services that are always considered Cosmetic include, but are not limited to, (1) removal of tattoos; (2) facelifts; (3) body contouring or body modeling; (4) injections to smooth wrinkles; (5) piercing ears or other body parts; (6) rhytidectomy or rhytidoplasty; (7) thighplasty; (8) brachioplasty; (9) keloid removal; (10) dermabrasion; (11)

chemical peels; and (12) laser resurfacing

55. Lipectomy for cosmetic purpose or for the treatment of variations in fat distribution.

56. Human growth hormones, unless Covered in the “Drugs – Prescription Coverage” section

57. Unless Covered in the “Drugs - Prescription Coverage” section, nicotine replacement therapy and aids to smoking cessation including, but not limited to, patches

58. Travel immunizations not received through Your pharmacy benefit.

59. Medical tourism or care received outside the United States when You choose to have an elective procedure in another country.

60. Non-emergency and non-urgent medical services or supplies received while traveling outside of the United States when treatment could have been reasonably delayed.

61. Home delivery of childbirth and any related services, unless the delivery is performed by a provider licensed by the state board of nursing as a registered nurse and duly certified as a nurse midwife by the American College of Nurse-Midwives.

SECTION VI - CLAIMS AND PAYMENT

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

CLAIMS

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

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

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

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

CLAIMS BILLING

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

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

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

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

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

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

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

a. You may submit a claim to Us to obtain a Coverage decision concerning whether the Plan will Cover that service. For example, if a pharmacy (1) does not provide You with a

prescribed medication; or (2) requires You to pay for that prescription, You may submit a claim to the Plan to obtain a Coverage decision about whether it is Covered by the Plan.

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

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

PAYMENT

If You received Covered Services from a Network Provider, We will pay the Network Provider directly. You authorize assignment of benefits to that Network Provider. If You have paid that Provider for the same claim, You must request repayment from that Provider. Covered Services will be paid at the In-Network Benefit level.

Out-of-Network Providers and Non-Contracted Providers may or may not file Your claims for You. A completed claim form for Covered Services must be submitted in a timely manner. After a completed claim form has been submitted, the Plan will pay the Provider directly for Covered Services, unless You submit proof of payment to Us before payment is made to the Provider. You authorize assignment of benefits to the Provider. If the Plan pays the Provider and You have paid that Provider for the same claim, You must request repayment from that Provider. You may be responsible for any unpaid Billed Charges. Our payment fully discharges Our obligation related to that claim.

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

b. 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.

c. When a claim is paid or denied, in whole or part, We will produce a Claim Summary. The Claim Summary, sometimes referred to as an Explanation of Benefits (EOB), 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 make the Claim Summary available to You at www.bcbst.com, or You can obtain it at no cost by calling Our consumer advisors at the number listed on Your membership ID card.

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

Payment for Covered Services is more fully described in the Schedule of Benefits.

"INFORMATION PLEASE.."

Whenever You need to file a claim, We can process it for You more efficiently if You complete a claim form. This will ensure that You provide all the information needed. Most providers will have claim forms, or You can request them from Us by calling the consumer advisor number shown on the membership ID card.

Mail all claim forms to:

BlueCross BlueShield of Tennessee
Claims Service Center
1 Cameron Hill Circle, Suite 0002
Chattanooga, Tennessee 37402-0002

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

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

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

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

2. Let Us know if You move.

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

SECTION VII - COORDINATION OF BENEFITS

This EOC includes the following Coordination of Benefits (COB) provision, which applies when a Member has coverage under more than one group contract or health care "Plan." Rules of this Section determine whether the benefits available under this EOC are determined before or after those of another Plan. In no event, however, will benefits under this EOC be increased because of this provision.

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

1. **Definitions**

   The following terms apply to this provision:

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

      (1) group, blanket, or franchise insurance;

      (2) a group BlueCross Plan, BlueShield Plan;

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

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

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

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

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

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

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

      "Plan" does not include individual or family:

      (1) Insurance contracts;

      (2) Subscriber contracts;

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

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

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

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

      (7) School accident-type coverages.

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

   b. "This Plan" refers to the part of the employee welfare benefit plan under which benefits for health care expenses are provided.

      The term "Other Plan" applies to each arrangement for benefits or

services, as well as any part of such an arrangement that considers the benefits and services of other contracts when benefits are determined.

c. Primary Plan/Secondary Plan.

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

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

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

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

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

(1) When a Plan provides benefits in the form of services, the reasonable cash value of a service is deemed to be both an Allowable Expense and a benefit paid.

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

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

2. **Order of Benefit Determination Rules**

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

a. Non-Dependent/Dependent

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

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

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

– benefits of the Plan of an active Employee covering the person as a Dependent;

– Medicare;

– benefits of the Plan covering the person as an Employee, Member, or Subscriber.

b. Dependent Child/Parents Not Separated or Divorced

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

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

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

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

c. Dependent Child/Separated or Divorced Parents

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

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

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

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

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

(5) If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in Paragraph 2(b), Dependent Child/Parents Not Separated or Divorced.

d. Active/Inactive Employee

The benefits of a Plan that covers a person as an Employee who is neither laid off nor retired are determined before those of a Plan that covers that person as a laid off or retired Employee. If the Other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Rule is ignored.

e. Longer/Shorter Length of Coverage

If none of the above Rules determines the order of benefits, the benefits of the Plan that has covered an Employee, Member, or Subscriber longer are determined before those of the Plan that has covered that person for the shorter term.

(1) To determine the length of time a person has been covered under a Plan, two Plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended.

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

– A change in the amount or scope of a Plan's benefits;

– A change in the entity that pays, provides, or administers the Plan's benefits; or

– A change from one type of Plan to another (such as, from a single Employer Plan to that of a multiple Employer plan.)

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

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

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

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

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

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

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

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

(4) If:

(a) The Non-complying Plan reduces its benefits so that the

Member receives less in benefits than he or she would have received had the Complying Plan paid, or provided its benefits as the Secondary Plan, and the Non-complying Plan paid or provided its benefits as the Primary Plan; and

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

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

3. **Effect on the Benefits of this Plan**

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

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

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

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

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

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

c. The administrator will not, however, consider the benefits of the Other Plan(s) in determining benefits under This Plan when:

(1) the Other Plan has a rule coordinating its benefits with those of This Plan and such rule states that benefits of the Other Plan will be determined after those of This Plan; and

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

4. **Right to Receive and Release Needed Information**

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

5. **Facility of Payment**

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

6. **Right of Recovery**

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

   a. The persons it has paid or for whom it has paid;

   b. Insurance companies; or

   c. Other organizations.

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

7. **Are You Also Covered by Medicare?**

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

SECTION VIII - GRIEVANCE

GRIEVANCE PROCEDURE

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 Our consumer advisors 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. a Claim Summary, sometimes referred to as the Explanation of Benefits or a 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.

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.

DESCRIPTION OF THE REVIEW PROCEDURES

Inquiry

An Inquiry is an informal process that may answer questions or resolve a potential Dispute. You should contact Our consumer advisors 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.

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. We may raise Your failure to initiate a Grievance in a timely manner as a defense if You file a lawsuit against the Administrator later.

Contact Our consumer advisors 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:

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

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

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 statement of the committee's understanding of Your Grievance;

The basis of the committee's decision; and

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.

Second Level Grievance

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

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

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

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

1. Grievance Process

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

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

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

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

2. Written Decision

After the hearing, the second level committee will meet in closed session to make a decision

concerning Your Grievance. That decision will be sent to You in writing. The written decision will contain:

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

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

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

Independent Review of Medical Necessity Determinations

If Your Grievance involves a Medical Necessity, Investigational or Rescission determination, or grievances with respect to Emergency Care Services rendered at an out-of-network hospital, items and services rendered by an Out-of-Network Provider at an in-network hospital (unless You agreed with the Provider prior to the services to accept out-of-network terms under regulatory requirements) and Authorized air ambulance services, 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 IX - SUBROGATION AND RIGHT OF REIMBURSEMENT

A. Subrogation Rights

The Plan shall be subrogated to and/or have the right to recover amounts paid to provide Covered Services to You for illnesses or injuries caused, insured or reimbursed by any parties, including the right to recover the reasonable value of services rendered by Network Providers. This subrogation right attaches automatically as a lien against any proceeds received by You from a third-party for the cost of care or treatment for any injury or illness caused by the third party for which medical payment is provided.

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 or underinsured 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 affected by any reductions due to 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. This reimbursement right attaches automatically as a lien against any proceeds received by You from a third-party for the cost of care or treatment for any injury or illness caused by the third party for which medical payment is provided. The Plan's first lien supersedes any right that You or Your estate may have to be "made whole". In other words, the Plan is entitled to the right of first reimbursement out of any recovery You or Your estate might procure regardless of whether You or Your estate have received compensation for any of Your damages or expenses, including Your or Your estate's attorneys' fees or costs. This priority right of reimbursement supersedes Your or Your estate's right to be made whole from any recovery, whether full or partial. In addition, You agree on behalf of Yourself and Your estate 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 on behalf of Yourself and Your estate to reimburse the Plan 100% first for any and all benefits provided through the Plan, and for any costs of recovering such amounts from any party 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 or their estate);
- Any auto or recreational vehicle insurance coverage or benefits including, but not limited to, uninsured or underinsured 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.

<u>Notice and Cooperation</u>

Members are required to notify the administrator 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

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

If You settle any claim or action against any party, You shall be deemed to have been made whole by the settlement and the Plan shall be entitled to immediately collect the present value of its subrogation/recovery rights from the settlement fund. You shall hold any such proceeds of settlement or judgment in trust for the exclusive 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.

You agree that the proceeds subject to the Plan's lien are Plan assets and You and/or the executor or administrator of Your estate will hold such assets as a trustee for the Plan's benefit and shall remit to the Plan, or its representative, such assets upon request. If represented by counsel, You agree that You and/or the executor or administrator of Your estate will direct such counsel to hold the proceeds subject to the Plan's lien in trust and to remit such funds to the Plan, or its representative, upon request. Should You and/or the executor or administrator of Your estate violate any portion of this section, the Plan shall have a right to offset future benefits otherwise payable under this plan to the extent of the value of the benefits advanced under this section to the extent not recovered by the Plan. You agree that by accepting payment of benefits pursuant to the Plan, You have assigned to the Plan the right of third-party insurance benefits or other recovery rights to which You may be entitled. You also acknowledge the Plan's right to reimbursement. You may be deemed ineligible for continued or future coverage under the Plan if You receive payment from a third-party tort-feasor, third-party insurer, third party for

medical payments or other individual or entity originally paid by the Plan for, or on Your behalf and you fail or refuse to promptly reimburse the Plan for amounts paid by the Plan. You should seek the advice of an attorney regarding the Plan's rights of subrogation and reimbursement.

Notwithstanding the foregoing, the Plan may waive any right of reimbursement if You are adjudged to be permanently disabled and thereby receive a corresponding benefit from the Social Security Administration or suffer a catastrophic loss, including but not limited to, death; long-term or permanent disability; loss of limb, extremity, or eye; permanent loss of fifty percent (50%) or more of sight or hearing; a prolonged vegetative state; permanent mental impairment; protracted complex recovery requiring multiple or successive surgeries; or any other similar life-altering loss.

Exhibit A
Request for Subrogation or Reimbursement Interest (RSRI) Form

BlueCross BlueShield of Tennessee, Inc.
Department of Subrogation

To whom it may concern:

I am a participant in the [name of plan] and am requesting that BlueCross BlueShield of Tennessee, Inc. determine the amount, if any, of the Plan's subrogation or reimbursement interest and provide notice to me of such interest.

Member Name
Date of Birth
Social Security Number
Date of Accident or Illness: _____
Last date of treatment: _____

Where did the accident or illness occur? _____
Please provide a brief description of the Member's injuries or illness:
_____
_____
_____
_____
_____
_____
Did the Member receive medications or dental treatment as a result of the injury or illness? (Please circle)
If the Member was involved in an accident please identify the type of injury: Auto; Medical Malpractice; Worker's Compensation; General Liability; (Circle one) Other
_____
_____
PERSON COMPLETING THIS FORM:
Relationship to Member (member, attorney, guardian, spouse, etc.):
_____
Company or Firm:
_____
Address:
_____
Phone: _____
Fax: _____

SECTION X - TERMINATION OF MEMBER COVERAGE

It is Your Employer's responsibility to notify You of changes in, or termination of, coverage under this plan in accordance with the following provisions:

- Coverage will terminate on the last date for which payment was made if:
  - the required premium charge or contribution is not paid, or
  - such person ceases to meet the eligibility requirements specified in the Schedule of Eligibility.
- If You elect continuation coverage as specified in a following paragraph You must pay to the Employer monthly premium charges for such coverage. Initial premium charges for continuation coverage will be due no later than 45 days after the date continuation coverage is elected. Employer will in turn remit to us such premium charges with payment of our regular billing.
- Dependent coverage will terminate on the first full day in which the Dependent no longer meets the definition of eligible Dependent.
- Dependent coverage for children attaining the age of 26 will end on the last day of the month that the child reaches 26 years of age.
- All coverage provided under this plan will end effective the date of its termination. No benefits will be provided for any service or supply rendered on or after such date.
- If a Member does not follow program guidelines, including paying required Copayments or Coinsurance to Network Providers, BlueCross, in its sole discretion, has the right to cancel a Member's coverage with 30 days' notice, subject to the Member's grievance rights.

LEAVE OF ABSENCE

Notwithstanding other provisions of this Section, continuous coverage during a leave of absence is permitted for up to six months if:

- the Employer continues to consider the Member an Employee and all other Employee benefits are also continued;
- any required premium contribution is paid;
- the leave is for a specific period of time established in advance of the leave; and
- the purpose of the leave is documented.

BENEFITS AFTER COVERAGE ENDS

Benefits for Hospital Services will be provided where a Member is hospitalized on the date this plan is terminated, in which case benefits for Hospital Services only will be provided for up to 90 days or until the Member is discharged, whichever occurs first.

The provisions of this Paragraph will not apply to a newborn child of a Subscriber for whom application for coverage was not received by the Plan within 31 days following such child's birth.

SECTION XI - CONTINUATION OF COVERAGE

Federal Law

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

1. Eligibility

   If You have been Covered by the Plan on the day before a qualifying event, You may be eligible for COBRA Continuation Coverage. The following are qualifying events for such Coverage:

   a. Subscribers. Loss of Coverage because of:

      – The termination of employment except for gross misconduct.

      – A reduction in the number of hours worked by the Subscriber.

   b. Covered Dependents. Loss of Coverage because of:

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

      – The death of the Subscriber.

      – Divorce or legal separation from the Subscriber.

      – The Subscriber becomes entitled to Medicare.

      – A Covered Dependent reaches the Limiting Age.

2. 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:

   b. The Subscriber's termination of employment, reduction in hours worked, death or entitlement to Medicare coverage; or

   c. 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.

3. 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.

4. 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.

5. Duration of Eligibility for COBRA Continuation Coverage

   COBRA Continuation Coverage is available for a maximum of:

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

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

   c. 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

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

6. Termination of COBRA Continuation Coverage

   After You have elected COBRA 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:

   a. The Payment for such Coverage is not submitted when due; or

   b. 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

   c. The ASA is terminated; or

   d. You become entitled to Medicare Coverage; or

   e. 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.

7. 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.

8. 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.

9. The Trade Adjustment Assistance Reform Act of 2002

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

SECTION XII - DEFINITION OF TERMS

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

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

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

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

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 Attachment C: Schedule of Benefits.

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

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

Behavioral Health Services – Any services or supplies to treat a mental or emotional condition or substance use disorder.

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.

Blue Distinction Centers for Transplants (BDCT) Network – A network of facilities and hospitals contracted with BlueCross (or with an entity on behalf of BlueCross) to

provide Transplant Services for some or all organ and bone marrow/stem cell transplant procedures Covered under this EOC. Facilities obtain designation as a BDCT by transplant type; therefore, a hospital or facility may be classified as a BDCT for one type of organ or bone marrow/stem cell transplant procedure but not for another type of transplant. This designation is important as it impacts the level of benefit You will receive.

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.

Brand Name Drug – A Prescription Drug identified by its registered trademark or product name given by its manufacturer, labeler or distributor.

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

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

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

Clinical Trials - Studies performed with human subjects to test new drugs or combinations of drugs, new approaches to surgery or radiotherapy or procedures to improve the diagnosis of disease and the quality of life of the patient.

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 Annual Benefit Period after any Deductible has been satisfied.

The Member may be responsible for the difference between Billed Charges and the Maximum Allowable Charge for a Covered Service if an Out-of-Network Provider's Billed Charges are more than the Maximum Allowable Charge for Services. In such case, the Member's total payment as a percentage of the Out-of-Network Provider's Billed Charges may exceed the Coinsurance Payment percentage set forth in the Schedule of Benefits.

Compound Drug – An outpatient Prescription Drug that is not commercially prepared by a licensed pharmaceutical manufacturer in a dosage form approved by the Food and Drug Administration (FDA) and contains at least one ingredient that cannot be dispensed without a Prescription.

Concurrent Review - refers to the determination under BlueCross' 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' Medical Director.

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

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

Copayments do not apply toward satisfying Deductibles.

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 persons of the opposite sex) 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 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.

Drug Formulary - Preferred – A list of specific generic and brand name Prescription Drugs Covered b**y** the Administrator **s**ubject to Quantity Limitations, Prior Authorization, and Step Therapy. 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.

Durable Medical Equipment - equipment that:

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

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

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

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

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

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

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

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

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

- Freestanding Dialysis Facility
- Ambulatory Surgical Facility
- Skilled Nursing/Rehabilitative Facility
- Substance Abuse Treatment Facility

- Residential Treatment Facility
- licensed birthing center
- other facilities approved by BlueCross' 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 providers' 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 or a licensed independent freestanding emergency department. Emergency Care Services may include items and services after the Member is stabilized and as part of outpatient observation or an inpatient or outpatient stay related to the Emergency.

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

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

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

Experimental and/or Investigational Drugs – Drugs or medicines that are labeled: "Caution – limited by Federal law to Investigational use."

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 an Annual Benefit Period. This Maximum can be satisfied by a combination of services provided by Network and Out-of-Network Providers.

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

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

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

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. Generic Drugs may be available as preferred Generic Drugs and non-preferred Generic Drugs and are identified on the Drug Formulary, which can be found at bcbst.com or by calling the Member Service number on the back of Your ID card.

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.

Hearing Aid(s) – An instrument to amplify sounds for those with hearing loss. There are 2 types of Hearing Aids: the air conduction type, which is worn in the external acoustic meatus, and the bone conduction type, which is worn in the back of the ear over the mastoid process. Examples of Hearing Aids that would fall within this definition are the Baha® system and the Otomag™ Hearing System. Cochlear implants are a prosthetic and are not considered Hearing Aids.

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.

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

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

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

Approved Hospice refers to a Hospice that:

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

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

b. Incapacitated dependents of Subscribers of new groups, or of Subscribers who are newly eligible under this Plan, are eligible for Coverage if they were covered under the Subscriber's or the Subscriber's spouse's previous health benefit plan. 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/Rehabilitative 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/Rehabilitative Facility setting.

Institution - a Hospital, Skilled Nursing/Rehabilitative 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.

a. 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.

b. 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.

c. 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.

d. 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**:**

a. Your medical records, or

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

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

d. 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

e. regulations or other official publications issued by the FDA and HHS, or

f. 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

g. 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.

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 upon the administrator's Out-of-Network fee schedule for the Covered Services rendered by Out-of-Network Providers, or as otherwise determined in accordance with the requirements of applicable state or federal law.

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

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

Medically Appropriate – services that have been determined by 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 variation 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.

Medication Assisted Treatment (MAT) – Treatment for persons diagnosed with indicated alcohol or substance use disorder with the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to treatment.

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

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.

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.

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.

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

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

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

Out-of-Network 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.

Out-of-Network Provider - a Physician, Hospital, or Other Provider that has not contracted with BlueCross to furnish services and to accept BlueCross' 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 an Annual Benefit Period. 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 Annual

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

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 and does not apply to the Out-of-Pocket Maximum.

Pharmacy/Pharmacies – A state or federally licensed establishment that is physically separate and apart from the office of a Practitioner, and where Prescription Drugs are dispensed by a pharmacist licensed to dispense such drugs under the laws of the state in which he or she practices.

Pharmacy and Therapeutics Committee or P&T Committee – A panel of the Administrator's participating pharmacists, Network Providers, medical directors and pharmacy directors that reviews medications for safety, efficacy and cost effectiveness. The P&T Committee evaluates medications for addition and deletion from the: (1) Drug Formulary; (2) Preferred Brand Drug list; (3) Prior Authorization Drug list; and (4) Quantity Limitation list. The P&T Committee may also set dispensing limits on medications.

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.

Plus90 Network – BlueCross' 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.

Practitioner(s) – A person licensed by the State to provide medical or behavioral health services. The services provided by a Practitioner must be within his or her specialty or scope of practice.

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

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.

Prescription – A written or verbal order issued by a physician or duly licensed Practitioner practicing within the scope of his or her licensure and authorized by law to a pharmacist or dispensing physician for a drug or drug product to be dispensed.

Prescription Contraceptive Drugs – Prescription drug products that are indicated for the prevention of pregnancy. The current list can be found on bcbst.com or by calling the number on the back of Your ID card.

Prescription Drug – A medication that may not be dispensed under applicable state or federal law without a Prescription.

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

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

Psychiatric Care - treatment of a mental illness (abnormal functioning of the mind or emotions regardless of origin). Psychiatric Care includes treatment for drug addiction or alcoholism.

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.

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

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/Rehabilitative Facility - provides convalescent and rehabilitative care on an Inpatient basis. Skilled nursing care must be provided by or under the supervision of a Physician. Neither:

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

will be considered a Skilled Nursing/Rehabilitative 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.

Specialty Drugs – Injectable, infusion and select oral medications that require complex care, including special handling, patient education and continuous monitoring. Specialty Drugs are listed on the Administrator's Specialty Drug list. Specialty Drugs are categorized as provider-administered or self-administered. Self-administered Specialty Drugs may be available as a preferred Specialty Drug or a non-preferred Specialty Drug, Generic Drug, Preferred Brand Drug or Non-Preferred Brand Drug and are identified on the Drug Formulary, which can be found at bcbst.com or by calling the Member Service number on the back of Your ID card.

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.

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.

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 Network – A network of hospitals and facilities, each of which has agreed to perform specific organ transplants. A hospital or facility may be in Our Transplant Network for one type of organ or bone marrow/stem cell transplant procedure but not for another type of transplant. The Transplant Network is not the same as the Blue Distinction Centers for Transplants (BDCT) Network.

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

Urgent Care – 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.

Urgent Care Center – A medical clinic with expanded hours that operates in a location distinct from a freestanding or hospital-based Emergency department.

Utilization Policy(ies) – Refers to any policy, guideline or limitation used by BlueCross in the determination of Coverage.

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.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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

- All stages of 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.

The Coverage will be provided subject to the same Coinsurance, Copays and Deductibles established for other benefits under this Plan. 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.

PRIVACY PRACTICES

Important Privacy Practices Notice

Effective Date: July 1, 2021

Important Privacy Information

This notice describes how information we have about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Legal obligations

The law requires Hamilton County Department of Education ("we," "us," "our") to give this notice of privacy practices to all our members. This notice lets you know about our legal duties and your rights when it comes to your information and privacy.

The law requires us to keep private all of the information we have about you, including your name, address, claims information, and other information that can identify you. The law requires us to follow all the privacy practices in this notice from the date on the cover until we change or replace it.

We have the right to make changes to our privacy practices and this notice at any time, but we will send you a new notice any time we do. Any changes we make to this notice will apply to all information we keep, including information created or received before we made changes.

Please review this notice carefully and keep it on file for reference. You may ask us for a copy of this notice at any time. To get one, please contact us at:

Hamilton County Department of Education

3074 Hickory Valley Road

Chattanooga, TN 37421

You may reach out to us at this address or phone number to ask questions or make a complaint about this notice or how we've handled your privacy rights. You may also submit a written complaint to the U.S. Department of Health and Human Services (HHS). Just ask us for their address, and we will give it to you.

We support your right to protect the privacy of the information we have about you. We won't retaliate against you if you file a complaint with HHS or us.

Organizations This Notice Covers

This notice applies to Hamilton County Department of Education. We may share our members' information with BlueCross BlueShield of Tennessee, Inc. and certain subsidiaries and affiliates of BlueCross BlueShield of Tennessee, Inc. as outlined in this notice. If BlueCross BlueShield of Tennessee, Inc. buys or creates new subsidiaries, they may also be required to follow the privacy practices outlined in this notice.

For additional information, including TTY/TDD users, please call **[_____]**. Para obtener ayuda en español, llame al **[_____].**

How We May Use and Share Your Information

We typically use your information for treatment, payment or health care operations. Sometimes we are allowed, and sometimes we are required, to use or disclose your information in other ways. This is usually to contribute to the public good, such as public health and research.

Some states may have more stringent laws. When those laws apply to your information, we follow the more stringent law. Specifically, Tennessee law and other state and federal laws require us to obtain your consent for most uses and disclosures of behavioral health information, alcohol and other substance use disorder information, and genetic information.

Ways We May Use and Share Your Information

The following are examples of how we may use or disclose your information in accordance with federal and state laws.

For your treatment: We may use or share your information with health care professionals who are treating you. For example, a doctor may send us information about your diagnosis and treatment plan so we can arrange additional care for you from other health care providers.

To make payments: We may use or share your information to pay claims for your care or to coordinate benefits covered under your health care coverage. For example, we may share your information with your dental provider to coordinate payment for dental services.

For health care operations: We may use or share your information to run our organization. For example, we may use or share it to measure quality, provide you with care management or wellness programs, and to conduct audit and other oversight activities.

To work with plan sponsors: We may share your information with your employer-sponsored group health plan (if applicable) for plan administration. Please see your plan documents for all ways a plan sponsor may use this information.

For underwriting: We may use or share your health plan information for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a health plan contract. We're not allowed to use or disclose genetic information for underwriting purposes.

Research: We may use or share your information in connection with lawful research purposes.

In the event of your death: If you die, we may share your health plan information with a coroner, medical examiner, funeral director or organ procurement organization.

To help with public health and safety issues: We can share information about you in certain situations, such as:

- Preventing disease
- Assisting public health authorities in controlling the spread of disease such as during pandemics
- Helping with product recalls
- Reporting negative reactions to medications
- Reporting suspected abuse, neglect or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

As required by law: We may use or share your information as required by state or federal law.

To comply with a court or administrative order: Under certain circumstances, we may share your information in response to a court or administrative order, subpoena, discovery request or other lawful process.

To address workers' compensation, law enforcement and other government requests: We can use or share information about you:

- For workers' compensation claims
- For law enforcement purposes, or with a law enforcement official
- With health oversight agencies for legal activities
- To comply with requests from the military or other authorized federal officials

With your permission: Some uses and disclosures of information require your written authorization, including certain instances if you want us to share your information with anyone. You may cancel your authorization in writing at any time, but doing so won't affect use or disclosure that happened while your authorization was valid.

For example, we would need your written authorization for:

- Most uses and disclosures of psychotherapy notes
- Uses and disclosures of your health plan information for marketing
- Sale of your health plan information
- Other uses and disclosures not described in this notice

We will let you know if any of these circumstances arise.

Your Individual Rights

To access your records: You have the right to view and get copies of your information that we maintain, with some exceptions. You must make a written request, using a form available from the Privacy Office, to get access to your information.

If you ask for copies of your information, we may charge you a reasonable, cost-based fee for staff time, and postage if you want us to mail the copies to you. If you ask for this information in another format, this charge will reflect the cost of giving you the information in that format. If you prefer, you may request a summary or explanation of your information, which may also result in a fee. For details about fees we may charge, please contact the Privacy Office.

To see who we've disclosed your information to: You have the right to receive a list of most disclosures we (or a business associate on our behalf) made of your information, other than for the purpose of treatment, payment or health care operations, within the past six years. This list will include the date of the disclosure, what information was disclosed, the name of the person or entity it was disclosed to, the reason for the disclosure and some other information.

If you ask for this list of disclosures more than once in a 12-month period, we may charge you based on the cost of responding to those additional requests. Please contact the Privacy Office for a more detailed explanation of these charges.

To ask for restrictions: You have the right to ask for restrictions on how we use or disclose your health plan information. We're not required to agree to these requests except in limited circumstances. If we agree to a restriction, you and we will agree to the restriction in writing. Please contact the Privacy Office for more information.

To get notified of a breach: The law requires us to notify you after the unauthorized acquisition, access, use, or disclosure of your unsecured information that compromises the security or privacy of the information. This notice must include various data points, such as:

- The date of the breach
- The type of data disclosed
- Who accessed, used or disclosed the information without permission
- Who received your information, if known
- What we did or will do to prevent future breaches

To ask for confidential communications: You have the right to ask us in writing to send your information to you at a different address or by a different method if you believe that sending information to you in the normal manner will put you in danger. We have to grant your request if it's reasonable. We will also need information from you, including how and where to communicate with you. Your request must not interfere with payment of your premiums.

If there's an immediate threat, you may make your request by calling the Member Service number on the back of your Member ID card or the Privacy Office. Please follow up your call with a written request as soon as possible.

To ask for changes to your personal information: You have the right to request in writing that we revise your information. Your request must be in writing and explain why the information should be revised. We may deny your request, for example, if we received (but didn't create) the information you want to amend. If we deny your request, we will write to let you know why. If you disagree with our denial, you may send us a written statement that we will include with your information.

If we grant your request, we will make reasonable efforts to notify people you name about this change. Any future disclosures of that information will be revised.

To request another copy of this notice: You can ask for a paper copy of this notice at any time, even if you got this notice by email or from our website. Please contact the Privacy Office at the address above.

To choose a personal representative: You may choose someone to exercise your rights on your behalf, such as a power of attorney. You may also have a legal guardian exercise your rights. We will work with you if you'd like to make this effective.

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

The company office or person to contact about coverage is:

_____

Name:

_____

Address:

_____

_____

_____

Phone:

The BlueCross BlueShield Plan to contact is:

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

The Subscriber Number shown on my identification card is:

_____

The "Effective Date" when my coverage begins is:

_____