

Example EOC
123456
February 1, 2014

BlueCross BlueShield of Tennessee

Evidence of Coverage

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

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

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

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Get the Most from Your Benefits

1. **Please Read Your Evidence of Coverage.** This Evidence of Coverage (this “EOC”) is part of the Group Agreement between BlueCross BlueShield of Tennessee, Inc. (BlueCross, Our, We, Us, or the “Plan”), and Your Group. “You” and “Your” mean a Subscriber. “Subscriber” means the individual to whom We have issued this EOC. “Member” means a Subscriber or a Covered Dependent. “Coverage” means the insurance benefits Members are entitled to under this EOC. This EOC describes the terms and conditions of Your Coverage from the Plan through the Group, and includes all riders and attachments, which are incorporated herein by reference. It replaces and supersedes any EOC that You have previously received from the Plan.

Please read this EOC carefully. It describes Your rights and duties as a Member. It is important to read the entire EOC. Certain services are not Covered by the Plan. Other Covered Services are limited.

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

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

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

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

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

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

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

3. **Your BlueCross BlueShield of Tennessee Identification Card.** Once Your Coverage becomes effective, You will receive a BlueCross BlueShield of Tennessee, Inc. Member identification (ID) card. Doctors and hospitals nationwide recognize it. The Member ID card is the key to receiving the

benefits of the health plan. Carry it at all times. Please be sure to show the Member ID card each time You receive medical services, especially whenever a Provider recommends hospitalization.

Our customer service number is on the back of Your Member ID card. This is an important phone number. Call this number if You have any questions. Also, call this number if You are receiving services from Providers outside of Tennessee or from Out-of-Network Providers to make sure all Prior Authorization procedures have been followed. See the section entitled “Prior Authorization” for more information.

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

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

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

If Your doctor refers You to another doctor, hospital or other health care Provider, or You see a covering physician in Your doctor’s practice, please make sure that the Provider is a Network Provider. When using Out-of-Network Providers, You will be responsible for the difference in the Provider’s billed charge and the Maximum Allowable Charge. This amount can be substantial.

6. **Ask Our consumer advisors** if the Provider is in the specific network shown on Your Member ID card. Since BlueCross has several networks, a Provider may be in one BlueCross network, but not in all of Our networks. Check out Our website, bcbst.com, for more information on Providers in each network.
7. **To find out** if BlueCross considers a recommended service to be Medically Necessary, please refer to Our Medical Policy Manual at bcbst.com. Search for Medical Policy Manual. Note that decisions about whether a service is experimental/investigational or medically necessary are for the purposes of determining what is Covered under the EOC. You and Your doctor decide what services You will receive.
8. **Prior Authorization is required for certain services.** See page 15 for a partial list. Make sure Your Provider obtains Prior Authorization before any planned hospital stays (except maternity admissions), skilled nursing and rehabilitative facility admissions, certain outpatient procedures, Advanced Radiological Imaging services, and before ordering certain Specialty Drugs , and Durable Medical Equipment. Call Our consumer advisors to find out which services require Prior Authorization. You can also call Our consumer advisors to find out if Your admission or other service has received Prior Authorization.
9. **To save money** when getting a prescription filled, **ask if a generic equivalent is available.**
10. In a true Emergency it is appropriate to go to an Emergency room (**see Emergency definition in the Definitions Section of this EOC.**) **However, most conditions are not Emergencies and are best handled with a call to Your doctor’s office.**

You also can call the 24/7 Nurseline, where a registered nurse will help You decide the right care at the right time in the right place. Call toll-free 1-800-818-8581 to speak one-on-one with a registered nurse or for hearing impaired dial TTY 1-888-308-7231.

11. Ask that Your Provider **report any Emergency admissions to BlueCross within 24 hours** or the next business day.
12. **Get a second opinion** before undergoing elective Surgery.
13. **When You are contemplating Surgery** or facing a medical decision, get support and advise by calling 1-800-818-8581 or for hearing impaired dial TTY 1-888-308-7231. Many conditions have more than one valid treatment option. Our nurses can help You discuss these treatment options with Your doctor so that You can make an informed decision. Some common conditions with multiple treatment options include:
 - Back pain;
 - Heart bypass surgery and angioplasty;
 - Women's health including uterine problems, hysterectomy, maternity, menopause, hormone replacement, and ovarian cancer;
 - arthritis of the major joints;
 - Men's health, including benign prostatic hyperplasia, cancer, and PSA testing;
 - Breast cancer and ductal carcinoma in situ, including surgical and other therapy, and reconstruction.
14. **Notify** Your Employer within 31 days of a qualifying event if changes in the following occur for You or any of Your dependents:
 - Address
 - Telephone number
 - Employment (change companies or terminate employment)
 - Status of any other health insurance You might have
 - Birth of additional dependents
 - Marriage or divorce
 - Death
 - Adoption

Enrolling in the Plan

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

A. Initial Enrollment Period

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

B. Open Enrollment Period

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

C. Adding Dependents

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

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

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

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

2. Any other new family dependent, (e.g. if the Subscriber marries) may be added as a Covered Dependent if the Subscriber completes and submits a signed Enrollment Form to the Group representative within 31 days of the date that person first becomes eligible for Coverage.
3. An Employee or eligible dependent who did not apply for Coverage within 31 days of first becoming eligible for Coverage under this Plan may enroll if:
 - a. he or she had other health care coverage at the time Coverage under this Plan was previously offered; and

- b. he or she stated, in writing, at the time Coverage under this Plan was previously offered, that such other Coverage was the reason for declining Coverage under this Plan; and
- c. such other Coverage is exhausted (if the other coverage was continuation Coverage under COBRA) or the other coverage was terminated because he or she ceased to be eligible due to involuntary termination or employer contributions for such Coverage ended; and
- d. he or she applies for Coverage under this Plan and the administrator receives the change form within 31 days after the loss of the other Coverage.

D. Late Enrollment

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

- 1. During a subsequent Open Enrollment Period; or
- 2. If the Employee acquires a new dependent, and the Employee applies for Coverage within 31 days.

E. Enrollment Upon Change in Status

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

- 1. You must request the change within 31 days of the change in status for the following events: (1) marriage or divorce; (2) death of the Employee's spouse or dependent; (3) change in dependency status; (4) Medicare eligibility; (5) Coverage by another Payor; (6) birth or adoption of a child of the Employee; (7) termination of employment, or commencement of employment, of the Employee's spouse; (8) switching from part-time to full-time, or from full-time to part-part status by the Employee or the Employee's spouse.
- 2. You must request the change within 60 days of the change in status for the following events: (1) loss of eligibility for Medicaid or CHIP coverage, or (2) becoming eligible to receive a subsidy for Medicaid or CHIP coverage.

When Coverage Begins

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

A. Effective Date of Group Agreement

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

B. Enrollment During an Open Enrollment Period

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

C. Enrollment During an Initial Enrollment Period

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

D. Newly Eligible Employees

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

E. Newly Eligible Dependents

1. Dependents acquired as the result of a marriage – Coverage will be effective on the day of the marriage unless otherwise agreed to by Group and the Plan;
2. Newborn children of the Subscriber or the Subscriber's spouse - Coverage will be effective as of the date of birth;
3. Dependents adopted or placed for adoption – Coverage will be effective as of the date of adoption or placement for adoption, whichever is first.

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

F. Eligibility For Extension of Benefits From a Prior Carrier

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

G. Actively at Work Rule

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

When Coverage Ends

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

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

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

B. Loss of Eligibility

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

C. Termination of Coverage For Cause

The Plan may terminate Your Coverage for cause, if:

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

D. Right To Request A Hearing

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

E. Payment For Services Rendered After Termination of Coverage

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

F. Extended Benefits

If a Member is hospitalized on the date the Group Agreement is terminated, benefits for Hospital Services will be provided: (1) for 60 days; (2) until the Member is Covered under another Plan; or (3) until the Member is discharged, whichever occurs first. The provisions of this paragraph will not

apply to a newborn child of a Subscriber if an application for Coverage for that child has not been made within 31 days following the child's birth.

Continuation of Coverage

A. Continuation of Coverage - Federal Law

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

1. Eligibility

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

a. Subscribers

Loss of Coverage because of:

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

b. Covered Dependents

Loss of Coverage because of:

- i. The termination of the Subscriber’s Coverage as explained in subsection (a), above.
- ii. The death of the Subscriber.
- iii. Divorce or legal separation from the Subscriber.
- iv. The Subscriber becomes entitled to Medicare. (Note: Medicare entitlement rarely qualifies a dependent for COBRA.)
- v. A Covered Dependent reaches the limiting age.

2. Enrolling for COBRA Continuation Coverage

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

- a. the Subscriber’s termination of employment, reduction in hours worked, death or entitlement to Medicare Coverage; or
- b. the Subscriber or Covered Dependent notifies the Group, in writing, within 60 days after any other qualifying event set out above.

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

and pay the Premium for Coverage, and submit a claim for those Covered Services as set forth in this EOC.

3. Premium Payment

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

4. Coverage Provided

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

5. Duration of Eligibility for COBRA Continuation Coverage

COBRA Continuation Coverage is available for a maximum of:

- a. 18 months if the loss of Coverage is caused by termination of employment or reduction in hours of employment; or
- b. 29 months of Coverage. If, as a qualified beneficiary who has elected 18 months of COBRA Continuation Coverage, You are determined to be disabled within the first 60 days of COBRA Continuation Coverage, You can extend Your COBRA Continuation Coverage for an additional 11 months, up to 29 months. Also, the 29 months of COBRA Continuation Coverage is available to all non-disabled qualified beneficiaries in connection with the same qualifying event. "Disabled" means disabled as determined under Title II or XVI of the Social Security Act. In addition, the disabled qualified beneficiary must:
 - i. 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
 - ii. 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:
 - i. the death of the Subscriber;
 - ii. loss of dependent child status under the Plan;
 - iii. the Subscriber becomes entitled to Medicare; or
 - iv. divorce or legal separation from the Subscriber; or

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

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

 - a. The Premium for such Coverage is not paid when due; or
 - b. You become Covered as either a Subscriber or dependent by another group health care plan; or
 - c. The Group Agreement is terminated; or
 - d. You become entitled to Medicare Coverage; or
 - e. The date that a disabled Member, who is otherwise eligible for 29 months of COBRA Coverage, is determined to no longer be disabled for purposes of the COBRA law.
- 7. The Trade Adjustment Assistance Reform Act of 2002 (TAARA) may have added to Your COBRA rights. If You lost Your job because of import competition or shifts of production to other countries, You may have a second COBRA Continuation election period. If You think this may apply to You, check with Your Employer or the Department of Labor.

B. State Continuation Coverage

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

1. Eligibility

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

2. Enrolling for State Continuation Coverage

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

3. Premium Payment

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

4. Coverage Provided

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

- a. 3 months; or
- b. 6 months after the end of a pregnancy that began before Your Coverage under the Group Agreement would have ended (before applying any continuation coverage); or
- c. 15 months if Your Coverage under the Group Agreement would end because of divorce or the death of the Subscriber.

5. Termination of State Continuation Coverage

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

- a. The end of the applicable period specified in subsection 4, above;
- b. The end of the period for which You paid the Premium for Coverage; or
- c. The termination date of the Group Agreement; or
- d. The date You become eligible for coverage under another group health benefits plan; or
- e. The date You become entitled to Medicare coverage.

C. Conversion Coverage

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

Conversion Coverage shall be:

1. The type of individual Coverage offered to converting Members as of the date of the termination of their Coverage under the Group Agreement;
2. Issued without evidence of insurability; and
3. Effective as of the date of the termination of Your Group Coverage. The Plan shall provide an Enrollment Form and information about that Conversion Coverage upon written request from You. You must submit a completed Enrollment Form and the Premium for Conversion Coverage to the Plan, within 31 days after the termination of Your Coverage under the Group Agreement.

D. Subscriber Interplan Transfers

If You move out of Tennessee into an area served by another BlueCross and/or BlueShield Plan (the "Other Plan"), and You wish to obtain Coverage thru that state's plan, Your Coverage can be transferred to the Plan serving Your new address. The Other Plan must offer You at least its "conversion" Plan through the Subscriber Interplan Transfer program.

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

1. You will receive credit for the length of Your enrollment with BlueCross under this Plan toward the conversion Plan's waiting periods, if any exist; and
2. Any physical or mental conditions Covered by BlueCross will be provided by the conversion Plan without a new waiting period, if one is required, if the conversion Plan offers this Coverage to others carrying the same Plan.

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

The Other Plan may also offer You Coverage outside the Subscriber Transfer program. Because these additional coverages are outside the program, that Plan may not apply time enrolled in Your BlueCross Plan waiting periods, if any exists.

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

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

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

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

F. Continued Coverage During a Military Leave of Absence

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

G. Continued Coverage During Other Leaves of Absence

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

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

1. Your Employer continues to consider the Subscriber an Employee, and all other Employee benefits are continued;
2. The leave is for a specific period of time established in advance; and
3. The purpose of the leave is documented.

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

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

Prior Authorization, Care Management, Medical Policy and Patient Safety

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

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

A. Prior Authorization

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

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

- Inpatient Hospital stays (except maternity admissions)
- Skilled nursing facility and rehabilitation facility admissions
- certain Outpatient Surgeries and/or procedures
- certain Specialty Drugs
- certain Prescription Drugs
- Advanced Radiological Imaging services
- Durable medical equipment (DME)
- Prosthetics
- Orthotics
- Certain musculoskeletal procedures (including, but not limited to spinal surgeries, spinal injections and hip, knee, and shoulder surgeries).
- Other services not listed at the time of publication may be added to the list of services that require Prior Authorization. Notice of changes to the Prior Authorization list will be made via Our Web site and the Member newsletter. You may also call Our consumer advisors at the number on the back of Your ID card to find out which services require Prior Authorization.

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

Network Providers in Tennessee will request Prior Authorization for You.

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

For the most current list of services that require Prior Authorization, call Our consumer advisors or visit Our website at bcbst.com.

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

Network Providers in Tennessee are required to comply with all Plan medical management programs. The Member is held harmless (not responsible for Penalties) if a Network Provider in

Tennessee fails to comply with Care Management program and Prior Authorization requirements, unless the Member agreed that the Provider should not comply with such requirements.

The Member is not held harmless if:

1. A Network Provider outside Tennessee (known as a BlueCard PPO Participating Provider) fails to comply with Care Management program and Prior Authorization requirements, or
2. Member obtains services from an Out-of-Network Provider.

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

B. Care Management

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

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

Lifestyle Coaching inspires, engages, and guides individuals to make lasting changes in their lives to improve their health and well-being. Through this voluntary program, You have access to a personal health assessment and personal wellness report, and a wellness portal filled with interactive health trackers and resources, as well as self-directed programs designed to support and motivate You to take charge of Your health. You also have unlimited access to Your dedicated lifestyle health coach. Communicate with Your coach via secure email or phone. Your lifestyle health coach can work with you on weight loss or weight management, improving nutrition, optimizing fitness, stress management, blood pressure management, cholesterol management, and tobacco cessation. To speak with a lifestyle health coach, call toll free 1-800-818-8581, select option 3.

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

Healthy Focus Disease Management - The Healthy Focus Disease Management Program is a voluntary program available to members with Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Diabetes, and Asthma. Through this program, You may receive outreach from our nurses. With this program, You may receive extra resources and personalized attention to help manage chronic health conditions and help You take better care of Yourself. To speak with a nurse today about your chronic condition, call toll free 1-800-818-8581, select option 1, or for hearing impaired dial TTY 1-888-308-7231.

Healthy Focus Nurseline - 24/7 Nurseline - This program offers You unlimited access to a registered nurse 24/7/365. Our nurses can assist you with symptom assessment, short term care decisions, or any health related question or concern. You may also call for decision support and advice when contemplating surgery, considering treatment options, and making major health decisions. Call toll free 1-800-818-8581, select option 2, or for hearing impaired dial TTY 1-888-308-7231.

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

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

In that event, the Plan may elect to offer alternative benefits for services not otherwise specified as Covered Services in Attachment A. Such benefits 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 the Member's attending physician and the Plan.

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

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

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

C. Medical Policy

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

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

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

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

D. Patient Safety

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

INTER-PLAN PROGRAMS

I. Out-of-Area Services

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

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

A. BlueCard® PPO Program

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

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

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

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

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

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

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

REMEMBER: You are responsible for receiving Prior Authorization from Us. If Prior Authorization is not received, Your benefits may be reduced or denied. Call the number on the back of Your Member ID card for Prior Authorization. In case of an Emergency, You should seek immediate care from the closest health care Provider.

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

1. Member Liability Calculation

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

2. Exceptions

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

C. BlueCard Worldwide® Program

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

Claims and Payment

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

A. Claims

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

1. A pre-service claim is any claim that requires approval of a Covered Service in advance of obtaining medical care as a condition of receipt of a Covered Service, in whole or in part.
2. A post-service claim is a claim for a Covered Service that is not a pre-service claim – the medical care has already been provided to You. Only post-service claims can be billed to the Plan, or You.
3. Urgent Care is medical care or treatment that, if delayed or denied, could seriously jeopardize: (1) the life or health of the claimant; or (2) the claimant's ability to regain maximum function. Urgent Care is also medical care or treatment that if delayed or denied, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the medical care or treatment. A claim for denied Urgent Care is always a pre-service claim.

B. Claims Billing

1. You should not be billed or charged for Covered Services rendered by Network Providers, except for required Member Payments. The Network Provider will submit the claim directly to Us.
2. You may be charged or billed by an Out-of-Network Provider for Covered Services rendered by that Provider. If You use an Out-of-Network Provider, You are responsible for the difference between Billed Charges and the Maximum Allowable Charge for a Covered Service. You are also responsible for complying with any of the Plan's medical management policies or procedures (including obtaining Prior Authorization of such Services, when necessary).

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

3. Claims for services received from Non-Contracted Providers are handled in the same manner as described above for Out-of-Network Providers.
4. 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.

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

Mail pediatric vision claims to BlueCross's Vision Claims Administrator:
EyeMed Vision Care®
ATTN: OON CLAIMS
P.O. Box 8504
Mason, OH 45040

5. A Network Provider or an Out-of-Network Provider may refuse to render a service, or reduce or terminate a service that has been rendered, or require You to pay for what You believe should be a Covered Service.
6. Providers may bill or charge for Covered Services differently. Network Providers are reimbursed based on Our agreement with them. Different Network Providers have different reimbursement rates for different services. Your Out-of-Pocket expenses can be different from Provider to Provider.

C. Payment

1. If You received Covered Services from a Network Provider, We will pay the Network Provider directly. These payments are made according to the Plan's agreement with that Network Provider. You authorize assignment of benefits to that Network Provider. Covered Services will be paid at the Network Benefit level.
2. Out-of-Network Providers may or may not file claims for You or Your Covered Dependents. A completed claim form for Covered Services must be submitted in a timely manner. We will reimburse You, unless You have assigned benefits to the Provider. You will be responsible for the difference in the Billed Charges and the Maximum Allowable Charge for that Covered Service. Our payment fully discharges Our obligation related to that claim.
3. Non-Contracted Providers may or may not file Your claims for You. Either way, the Network Benefit level shown in Attachment C : Schedule of Benefits will apply to claims for Covered Services received from Non-Contracted Providers. However, You will be responsible for the difference between what the Plan pays and what the Non-Contracted Provider charges.
4. If the Group Agreement is terminated, all claims for Covered Services rendered prior to the termination date, must be submitted to the Plan within 1 year and 90 days from the date the Covered Services was received.
5. We will pay benefits within 30 days after We receive a claim form that is complete. Claims are processed in accordance with current industry standards, and based on Our information at the time We receive the claim form.
6. At least monthly, You will receive an Explanation of Benefits (EOB) that describes how a claim was treated. For example, paid, denied, how much was paid to the Provider, and also let You know if You owe an additional amount to that Provider. The Plan will make the EOB available to You at bcbst.com, or by calling Our consumer advisors at the number on the back of Your Member ID card.
7. You are responsible for paying any applicable Copayments, Coinsurance, or Deductible amounts to the Provider. If We pay such amounts to a Provider on Your behalf, We may collect those amounts directly from You.

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

Coordination of Benefits

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

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

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

A. Definitions

The following terms apply to this provision:

1. Types of Coverages to which this provision applies and with which coordination of benefits is allowed includes any form of medical or dental coverage including:
 - a. Group, blanket, or franchise insurance;
 - b. A group BlueCross Plan, BlueShield Plan;
 - c. Group or group-type coverage through HMOs or other prepayment, group practice and individual practice plans;
 - d. Coverage under labor management trust Plans or employee benefit organization Plans;
 - e. Coverage under government programs to which an employer contributes or makes payroll deductions;
 - f. Coverage under a governmental Plan or coverage required or provided by law;
 - g. Medical benefits coverage in group, group-type, and individual automobile “no-fault” and traditional automobile “fault” type contracts;
 - h. Coverage under Medicare and other governmental benefits; and
 - i. Any other arrangement of health coverage for individuals in a group.
2. Specifically excluded from the application of coordination of benefit rules are individual (or the individual’s family)
 - a. Insurance contracts;
 - b. Subscriber contracts;
 - c. Coverage through Health Maintenance (HMO) organizations;
 - d. Coverage under other prepayment, group practice and individual practice plans;
 - e. Public medical assistance programs (such as TennCaresm);
 - f. Group or group-type hospital indemnity benefits of \$100 per day or less;
 - g. 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.

3. In this section only, “This Plan” refers to the part of the Group Agreement under which benefits for health care expenses are provided.

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

4. Primary Plan/Secondary Plan

- a. The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to the Other Plan covering You.
- b. 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.
- c. 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.
- d. 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 Other Plans.

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

- a. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense, and a benefit paid.
- b. The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense under the above definition, unless the patient’s stay in a private hospital room is Medically Necessary, either in terms of generally accepted medical practice, or as specifically defined in the Plan.
- c. 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.

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

B. Order of Benefit Determination Rules

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

1. 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:

- a. if the person is also a Medicare beneficiary and,
- b. 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:

- i. benefits of the plan of an active Employee covering the person as a Dependent;
- ii. Medicare;
- iii. benefits of the plan covering the person as an Employee, Member, or Subscriber.

2. Dependent Child/Parents Not Separated or Divorced

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

- a. 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
- b. If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time.
- c. 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, This Plan and the Other Plan do not agree on the order of benefits, the rule in the Other Plan will determine the order of benefits.

3. 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:

- a. First, the plan of the parent with custody of the child;
- b. Then, the plan of the spouse of the parent with the custody of the child; and
- c. Finally, the plan of the parent not having custody of the child.
- d. 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.
- e. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above, Dependent Child/Parents Not Separated or Divorced.

4. Active/Inactive Employee

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

5. 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.

- a. To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the claimant was eligible under the second within twenty-four hours after the first ended.
- b. The start of the new plan does not include:
 - i. A change in the amount or scope of a plan's benefits;
 - ii. A change in the entity that pays, provides, or administers the plan's benefits; or
 - iii. A change from one type of plan to another (such as, from a single Employer plan to that of a multiple Employer plan).
- c. 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.

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

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

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

- a. If This Plan is the Primary Plan, it will provide its benefits on a primary basis.
- b. 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.
- c. 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.
- d. If:
 - i. The Non-complying Plan reduces its benefits so that the Employee, Subscriber or Member receives less in benefits than he or she would have received had the Complying Plan paid, or provided its benefits as the Secondary Plan, and the Non-complying Plan paid or provided its benefits as the Primary Plan; and
 - ii. 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.

C. 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.

1. Benefits of This Plan will be reduced when the sum of:
 - a. The benefits that would be payable for the Allowable Expenses under This Plan, in the absence of this COB provision; and
 - b. 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.
2. When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion, and is then charged against any applicable benefit limit of This Plan.

D. 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.

E. 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.

F. Right of Recovery

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

1. The persons it has paid or for whom it has paid;
2. Insurance companies; or
3. Other organizations.

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

G. 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 number on the back of Your Member ID card if You have any questions.

Grievance Procedure

A. Introduction

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

Adverse Benefit Determination means:

1. A determination by a health carrier or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health carrier's health benefit plan does not meet the health carrier's requirements for medical necessity, appropriateness, healthcare setting, level of care or effectiveness and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit;
2. 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
3. Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment for, in whole or in part, a benefit.

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

1. This Grievance Procedure must be exhausted as required by ERISA. However, nothing in this EOC shall prevent You from filing a complaint with the Tennessee Department of Commerce and Insurance, but such complaint is outside of, separate from, and in addition to this Grievance Procedure.
2. The Procedure can only resolve Disputes that are subject to Our control.
3. You cannot use this Procedure to resolve a claim that a Provider was negligent. Network Providers are independent contractors. They are solely responsible for making treatment decisions in consultation with their patients. You may contact the Plan, however, to complain about any matter related to the quality or availability of services, or any other aspect of Your relationship with Providers.
4. Under this Procedure:
 - a. If a Provider does not render a service, or reduces or terminates a service that has been rendered, or requires You to pay for what You believe should be a Covered Service, You may submit a Claim to the Plan to obtain a determination concerning whether the Plan will cover that service. As an example, if a pharmacy does not provide You with a prescribed medication or requires You to pay for that prescription, You may submit a Claim to the Plan to obtain a determination about whether it is Covered by the Plan. Providers may be required to hold You harmless for the cost of services in some circumstances.

- b. Providers may also appeal an Adverse Benefit Determination through the Plan's Provider dispute resolution procedure.
 - c. A Plan determination will not be an Adverse Benefit Determination if: (1) a Provider is required to hold You harmless for the cost of services rendered; or (2) until the Plan has rendered a final Adverse Benefit Determination in a matter being appealed through the Provider dispute resolution procedure.
- 5. You may request a form from the Plan to authorize another person to act on Your behalf concerning a Dispute.
 - 6. The Plan and You may agree to skip one or more of the steps of this Procedure if it will not help to resolve Our Dispute.
 - 7. Any Dispute will be resolved in accordance with applicable Tennessee or Federal laws and regulations, the Group Agreement and this EOC.

B. Description of the Review Procedures

1. Inquiry

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

2. Grievance

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

Contact Our consumer advisors at the number on the back of Your Member 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.

a. Grievance Hearing

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

b. Written Decision

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

- i. For a pre-service claim, within 30 days of receipt of Your request for review;
- ii. For a post-service claim, within 60 days of receipt of Your request for review; and
- iii. 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:

- i. A statement of the committee's understanding of Your Grievance;
- ii. The basis of the committee's decision; and
- iii. Reference to the documentation or information upon which the committee based its decision. The Plan will send You a copy of such documentation or information, without charge, upon written request.

C. Second Level Grievance Procedure

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

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

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

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

1. Grievance Hearing

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

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

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

- b. Information presented during the hearing. Second level Grievance committee members may ask You questions during the hearing. You may make a closing statement to the committee at the end of the hearing.
- c. If You wish to bring a personal representative with You to the hearing, You must notify Us at least 5 days in advance and provide the name, address and telephone number of Your personal representative.

2. Written Decision

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

- a. A statement of the second level committee's understanding of Your Grievance;
- b. The basis of the second level committee's decision; and
- c. Reference to the documentation or information upon which the second level committee based its decision. Upon written request, We will send You a copy of any such documentation or information, without charge.

D. Independent Review of Medical Necessity Determinations or Coverage Rescissions

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

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

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

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

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

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

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

Statement of ERISA Rights

For the purposes of this section, the term, “Plan” means the employee welfare benefit plan sponsored by the Plan Sponsor (usually, Your Employer). The Employee Retirement Income Security Act of 1974 (ERISA) entitles You, as a Member of the Group under this Plan, to:

1. Examine, without charge, at the office of the Plan Administrator (Plan Sponsor, usually Your Employer) and at other specified locations, such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration;
2. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator (Plan Sponsor, i.e., Your Employer). The Plan Administrator may make a reasonable charge for these copies; and
3. Receive a summary of the plan’s annual financial report. The Plan Administrator (Plan Sponsor, usually Your Employer) is required by law to furnish each participant with a copy of this summary annual report.
4. Obtain a statement telling You whether You have a right to receive a pension at normal retirement age and if so, what Your benefits would be at normal retirement age if You stop working under the Plan now. If You do not have a right to a pension, the statement will tell You how many more years You have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.
5. Continue Your health care Coverage if there is a loss of Coverage under the Plan as a result of a qualifying event. You may have to pay for such Coverage. Review the Continuation of Coverage section of this EOC for the rules governing Your COBRA Continuation Coverage rights.

If You have Creditable Coverage from a prior employer’s Plan, that Creditable Coverage may reduce or eliminate any Pre-existing Condition Waiting Period under this Plan. You should be given a Certificate of Creditable Coverage, free of charge, when: (1) You lose Coverage under the Plan; (2) You become entitled to elect COBRA Continuation Coverage; and (3) Your COBRA Continuation Coverage ceases if You request the Certificate of Creditable Coverage before losing Coverage, or within 24 months after losing Coverage.

Without evidence of Creditable Coverage, You may be subject to a Pre-existing Condition exclusion for 12 months (18 months for Late Enrollees) after You enroll for Coverage under this Plan.

In addition to creating rights for You and other employees, ERISA imposes duties upon the people who are responsible for the operation of Your employee benefit plan. The people who operate Your plan are called “fiduciaries” of the plan. They must handle Your plan prudently and in the interest of You and other plan participants and beneficiaries. No one, including Your Employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA. If Your claim for welfare benefits is denied, in whole or in part, You have a right to know why this was done and to obtain copies of documents relating to the decision without charge. You have the right to have the Plan review Your claim and reconsider it.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30

days, You may file suit in a federal court. In such a case, the court may require the Plan Administrator (Plan Sponsor, i.e., Your Employer) to provide the materials and pay You up to \$110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If Your claim for benefits is denied or ignored, in whole or in part, You may file suit in a state or federal court. Also, if You disagree with the plan's decision (or lack thereof) concerning the qualified status of a domestic relations order or a Medical Child Support Order, You may file suit in federal court. If plan fiduciaries misuse the Plan's money or if You are discriminated against for asserting Your rights, You may seek assistance from the U. S. Department of Labor, or may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees; for example, it may order You to pay these expenses if it finds Your claim is frivolous.

If You have any questions about Your plan, You should contact the Plan Administrator (Plan Sponsor, i.e., Your Employer). If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Plan Sponsor, You should contact the nearest Office of the Employee Benefits Security Administration, U. S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Notice of Privacy Practices

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

PLEASE REVIEW IT CAREFULLY

LEGAL OBLIGATIONS

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

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

You may request a copy of this notice of privacy practices at any time by contacting BlueCross BlueShield of Tennessee, Privacy Office.

ORGANIZATIONS COVERED BY THIS NOTICE

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

USES AND DISCLOSURES OF MEDICAL INFORMATION

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

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

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

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

AUTHORIZATIONS: You may provide written authorization to use Your medical information or to disclose it to anyone for any purpose. You may revoke Your authorization in writing at any time. That revocation will not affect any use or disclosure permitted by Your authorization while it was in effect. We cannot use or disclose Your medical information for any reason except those described in this notice, without Your written authorization. Examples of where an authorization would be required: Most uses and disclosures of psychotherapy notes (if recorded by a covered entity), uses and disclosures for marketing purposes, disclosures that constitute a sale of PHI, other uses and disclosures not described in the NOPP.

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

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

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

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

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

PLAN SPONSORS: Your medical information and the medical information of others enrolled in Your group health plan may be disclosed to Your plan sponsor in order to perform plan administration functions. Please see Your plan documents for a full description of the uses and disclosures the plan sponsor may make of Your medical information in such circumstances.

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

UNDERWRITING: Your medical information may be received for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a health insurance or benefits contract. If the Plan does not issue that contract, Your medical information will not be used or further disclosed for any other purpose, except as required by law. **Additionally, health plans are prohibited from using or disclosing genetic information of an individual for underwriting purposes pursuant to the Genetic Information Nondiscrimination Act of 2008 (GINA).**

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

INDIVIDUAL RIGHTS

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

contact the Privacy Office. The Plan will require advance payment before copying Your medical information. **You have the right to notice following a breach of unsecured protected health information. The notice of a breach of unsecured protected health information shall at a minimum include the following: The date of the breach, the type of data disclosed in the breach, who made the non-permitted access, use or disclosure of unsecured protected health information and who received the non-permitted disclosure, and what corrective business action was or will be taken to prevent further non-permitted access, uses or disclosures of unsecured protected health information.**

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

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

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

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

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

QUESTIONS AND COMPLAINTS

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

If:

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

3. You wish to request the Plan communicate with You by alternative means or at alternative locations;

please contact the Privacy Office.

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

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

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

General Legal Provisions

The Plan is an Independent Licensee of the BlueCross BlueShield Association

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

Relationship with Network Providers

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

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

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

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

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

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

to use certain providers or facilities, or to reduce Your Out of-Pocket costs, You may be required to obtain precertification. For information on precertification, contact Your plan administrator.

Women's Health and Cancer Rights Act of 1998

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

reconstruction of the breast on which the mastectomy was performed;

Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas

in a manner determined in consultation with the attending physician and the patient. The coverage may be subject to Coinsurance and Deductibles consistent with those established for other benefits. Please refer to the body of the EOC or call Our consumer advisors for more details.

Uniformed Services Employment and Reemployment Rights Act of 1994

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

Governing Laws

Tennessee laws govern Your benefits.

Subrogation and Right of Recovery

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

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

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

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

If a Member settles any claim or action against any party, that Member shall be deemed to have been made whole by the settlement and the Plan shall be entitled to immediately collect the present value of its subrogation and recovery rights from the settlement fund. Any such proceeds of settlement or judgment shall be held in trust by the Member for the benefit of the Plan. The Plan shall also be entitled to recover reasonable attorneys' fees incurred in collecting proceeds held by the Member in such circumstances.

Definitions

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

1. **Actively At Work** - The performance of all of an Employee's regular duties for the Group on a regularly scheduled workday at the location where such duties are normally performed. An Employee will be considered to be Actively At Work on a non-scheduled work day (which would include a scheduled vacation day) only if he or she was Actively At Work on the last regularly scheduled work day.
2. **Acute** - An illness or injury that is both severe and of short duration.
3. **Advanced Radiological Imaging** – Services such as MRIs, MRAs, CAT scans, CT scans, PET scans, nuclear medicine and similar technologies.
4. **Annual Benefit Period** - The 12-month period under which Your benefits are administered, as noted in Attachment C: Schedule of Benefits.
5. **Average Wholesale Price** – A published suggested wholesale price of the drug by the manufacturer.
6. **Behavioral Health Services** - Any services or supplies that are Medically Necessary and Appropriate to treat: a mental or nervous condition; alcoholism; chemical dependence; drug abuse or drug addiction.
7. **Benefit Period** – a 12-month period based on the last date of service during which any benefit limits accumulate/are counted.
8. **Billed Charges** – The amount that a Provider or Dentist charges for services rendered. Billed Charges may be different from the amount that BlueCross determines to be the Maximum Allowable Charge for services.
9. **BlueCard PPO Participating Provider** – A physician, hospital, licensed skilled nursing facility, home health care Provider or other Provider contracted with other BlueCross and/or BlueShield Plans, BlueCard PPO Plans and/or Authorized by the Plan to provide Covered Services to Members.
10. **BlueCross, Our, Plan, Us or We** – BlueCross BlueShield of Tennessee, Inc.
11. **Care Management** – A program that promotes cost effective coordination of care for Members with complicated medical needs, chronic illnesses, and/or catastrophic illnesses or injuries.
12. **CHIP – The State** Children's Health Insurance Program established under title XXI of the Social Security Act (42 U.S.C. 1396 et. seq.)
13. **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.
14. **Coated Lenses** – A substance added to a finished lens on one or both surfaces.
15. **Coinsurance** – Sharing of the cost of Covered Services by the Plan and You, after Your Deductible has been satisfied. The Plan's Coinsurance amounts for network and out-of-network Covered Services are specified in Attachment C: Schedule of Benefits. Your Coinsurance is calculated as 100% minus the Plan's Coinsurance. In addition to Your Coinsurance, You are responsible for the difference between the Billed Charge and the Maximum Allowable Charge for Covered Services if

the Billed Charge of a Non-Contracted Provider or an Out-of-Network Provider is more than the Maximum Allowable Charge for such services.

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

16. **Complications of Pregnancy** – Conditions requiring Hospital Confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or caused by pregnancy, such as Acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, non-elective cesarean section, ectopic pregnancy that is terminated, termination of pregnancy when the fetus is not viable, and spontaneous termination of pregnancy, that occurs during a period of gestation in which a viable birth is not possible.

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

17. **Compound Drug** - An outpatient Prescription Drug that is not commercially prepared by a licensed pharmaceutical manufacturer in a dosage form approved by the food and drug administration (FDA) and that contains at least one ingredient classified as a Legend Drug.
18. **Concurrent Review** – The process of evaluating care during the period when Covered Services are being rendered.
19. **Copayment** – The dollar amount specified in Attachment C: Schedule of Benefits that You are required to pay directly to a Provider or Network Pharmacy for certain Covered Services. You must pay such Copayments at the time You receive those Services.
20. **Cosmetic Service** – Any surgical or non-surgical treatment, drugs or devices intended to alter or reshape the body for the purpose of improving appearance or self-esteem. Our medical policy establishes the criteria for what is cosmetic, and what is Medically Necessary and Appropriate.
21. **Covered Dependent** - A Subscriber's family members who: (1) meet the eligibility requirements of this EOC, (2) have been enrolled for Coverage; and (3) for whom the Plan has received the applicable Premium for Coverage.
22. **Covered Family Members** – A Subscriber and his or her Covered Dependents.
23. **Covered Services, Coverage or Covered** - Those Medically Necessary and Appropriate services and supplies that are set forth in Attachments A-C of this EOC, (that is incorporated by reference). Covered Services are subject to all the terms, conditions, exclusions and limitations of the Group Agreement and this EOC.
24. **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.
25. **Deductible** - The dollar amount, specified in Attachment C: Schedule of Benefits that You must incur and pay for Covered Services during an Annual Benefit Period before the Plan provides benefits for

services. If a claim includes dates of service that span two Annual Benefit Periods, benefits may be subject to a Deductible for each Annual Benefit Period. There are 2 separate Deductible amounts – one for Network Providers and one for Out-of-Network Providers. The Deductible will apply to the Out-of-Pocket Maximum(s).

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

26. **Dentist** - A doctor of dentistry duly licensed and qualified under applicable laws to practice dentistry at the time and place Covered Services are performed.
27. **Drug Formulary** - a list designating which Prescription Drugs and drug products are approved for reimbursement under a particular Prescription Drug program. This list is subject to periodic review and modification by the Plan.
28. **Effective Date** - The date Your Coverage under this EOC begins.
29. **Eligible Providers** - All services must be rendered by a Practitioner or Provider type listed in the Plan's Provider Directory of Network Providers, or as otherwise required by Tennessee law. The services provided by a Practitioner must be within his/her/its specialty, degree, licensure or accreditation. All services must be rendered by the Practitioner or Provider, or the delegate actually billing for the Practitioner or Provider, and be within the scope of his/her/its licensure.
30. **Emergency** – A sudden and unexpected medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect to result in:
 - a. serious impairment of bodily functions; or
 - b. serious dysfunction of any bodily organ or part; or
 - c. placing the prudent layperson's health in serious jeopardy.Examples of Emergency conditions include: (1) severe chest pain; (2) uncontrollable bleeding; or (3) unconsciousness.
31. **Emergency Care Services** - Those services and supplies delivered in a hospital emergency department that are Medically Necessary and Appropriate in the treatment of an Emergency.
32. **Employee** - A person who fulfills all eligibility requirements established by the Group and the Plan.
33. **Enrollment Form** – A form or application that must be completed in full by the eligible Employee before he/she will be considered for Coverage under the Plan. Your Group may have You use an electronic form to enroll, rather than a paper form.
34. **ERISA** - The Employee Retirement Income Security Act of 1974, as amended.
35. **Experimental and/or Investigational Drugs** – Drugs or medicines that are labeled: "Caution – limited by federal law to Investigational use."
36. **Generic Drug** - A Prescription Drug that has the same active ingredients, strength or concentration, dosage form and route of administration as a Non-Preferred Brand Drug. The FDA approves each Generic Drug as safe and effective as a specific Non-Preferred Brand Drug.
37. **Group Agreement or Agreement** – The arrangements between the Plan and the Group, including this EOC, the Employer Group Application, any Riders, any amendments, and any attachments to the

Agreement or this EOC. If there is any conflict between the Group Agreement and this EOC, the Group Agreement shall be controlling.

- 38. **Group or Employer** – A corporation, partnership, union or other entity that is eligible for Group Coverage under State and Federal laws, and the Plan’s Underwriting Guidelines; and that enters into an Agreement with the Plan to provide Coverage to its Employees and their eligible Dependents.
- 39. **Habilitative Therapy** - therapies or other treatments that enable a person (*e.g.*, a child) with a disability to attain functional abilities, or lessen the deterioration of function over time.
- 40. **Hospital Confinement** – When You are treated as a registered bed patient at a Hospital or other Provider facility and incur a room and board charge.
- 41. **Hospital Services** - Covered Services that are Medically Appropriate to be provided by an Acute care hospital.
- 42. **Incapacitated Child** – an unmarried child who is, and continues to *be*, both (1) incapable of self-sustaining employment by reason of intellectual disabilities (excluding mental illness) or physical handicap; and (2) chiefly dependent upon the Subscriber or Subscriber’s spouse for economic support and maintenance.

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

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

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

- 43. **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. 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 received 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.
44. **Late Enrollee** – An Employee or eligible Dependent who fails to apply for Coverage within: (1) 31 days after such person first became eligible for Coverage under this EOC; or (2) within a subsequent Open Enrollment Period.
45. **Legend Drugs** – A drug that, by law, can be obtained only by Prescription and bears the label, “Caution: Federal law prohibits dispensing without a Prescription.”
46. **Limiting Age (or Dependent Child Limiting Age)** - The age at which a child will no longer be considered an eligible Dependent.
47. **Mail Order Network** – BlueCross BlueShield of Tennessee’s (BlueCross) network of mail service pharmacy facilities.
48. **Maintenance Care** – Medical services (including skilled services and therapies), prescription drugs, supplies and equipment for chronic, static or progressive medical conditions where the medical services (including skilled services and therapies), drugs, supplies and equipment: (1) fail to contribute toward cure; (2) fail to improve unassisted clinical function; (3) fail to significantly

improve health; and (4) are indefinite or long-term in nature. This exclusion also applies to drugs used to treat chemical dependency.

49. **Mandated Diabetes Supplies List** - In accordance with Tenn. Code Ann. § 56-7-2605, the following equipment and supplies for the treatment of diabetes must be included in the coverage provided pursuant to subsection (b), when prescribed by a physician as medically necessary for the care of an individual patient with diabetes:
- A. Blood glucose monitors and blood glucose monitors for the legally blind;
 - B. Test strips for blood glucose monitors;
 - C. Visual reading and urine test strips;
 - D. Insulin;
 - E. Injection aids;
 - F. Syringes;
 - G. Lancets;
 - H. Insulin pumps, infusion devices, and appurtenances thereto;
 - I. Oral hypoglycemic agents;
 - J. Podiatric appliances for prevention of complications associated with diabetes; and
 - K. Glucagon emergency kits.
50. **Maximum Allowable Charge** – The amount that the Plan, at its discretion, has determined to be the maximum amount payable for a Covered Service. That determination will be based upon the Plan's contract with a Network Provider for Covered Services rendered by that Provider or the amount payable based on the Plan's fee schedule for the Covered Services for Services rendered by Out-of-Network Providers.
51. **Medicaid** – The program for medical assistance established under title XIX of the Social Security Act (42 U.S.C. 1396 et. seq.)
52. **Medical Director** - The physician designated by the Plan, or that physician's designee, who is responsible for the administration of the Plan's medical management programs, including its authorization program.
53. **Medically Appropriate** – Services which have been determined by BCBST in its discretion to be of value in the care of a specific Member. To be Medically Appropriate a service must meet all of the following:
- a. be Medically Necessary;
 - b. be consistent with generally accepted standards of medical practice for the Member's medical condition;
 - c. be provided in the most appropriate site and at the most appropriate level of service for the Member's medical condition;
 - d. not be provided solely to improve a Member's condition beyond normal variation in individual development, appearance and aging;
 - e. not be for the sole convenience of the Provider, Member or Member's family.

54. **Medically Necessary or Medical Necessity** – "Medically Necessary" means procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical Practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:
- a. in accordance with generally accepted standards of medical practice; and
 - b. clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and
 - c. not primarily for the convenience of the patient, physician or other health care Provider; and
 - d. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

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

55. **Medicare** - Title XVIII of the Social Security Act, as amended, and Coverage under this program.
56. **Member, You, Your** - Any person enrolled as a Subscriber or Covered Dependent under a Group Agreement.
57. **Member Payment** – The dollar amounts for Covered Services that You are responsible for as set forth in Attachment C: Schedule of Benefits, including Copayments, Deductibles, Coinsurance and Penalties. The Plan may require proof that You have made any required Member Payment.
58. **Necessary Dental Care** – Any treatment or service prescribed by a Dentist that the Plan determines to be necessary and appropriate.
59. **Network Benefit** – The Plan's payment level that applies to Covered Services received from a Network Provider. See Attachment C: Schedule of Benefits.
60. **Network Dentist** - A Dentist who has signed a Preferred Dental Agreement with the Plan.
61. **Network Pharmacy** - a Pharmacy that has entered into a network pharmacy agreement with the Plan or its agent to legally dispense Prescription Drugs to You, either in person or through mail order.
62. **Network Provider** - A Provider who has contracted with the Plan to provide access to benefits to Members at specified rates. Such Providers may be referred to as BlueCard PPO participating Providers, participating Hospitals, Transplant Network, etc.
63. **Non-Contracted Provider** – A Provider that renders Covered Services to a Member but is in a specialty category or type with which We do not contract. A Non-Contracted Provider is different from an Out-of-Network Provider. A Non-Contracted Provider is not eligible to hold a contract with the Plan. Provider types that are considered Non-Contracted can change as We contract with different Provider types. A Provider's status as a Non-Contracted Provider, Network Provider, or Out-of-Network Provider can and does change. We reserve the right to change a Provider's status.
64. **Non-Preferred Brand Drug or Elective Drug** - a Prescription Drug identified by its registered trademark or product name given by its manufacturer, labeler or distributor that is not considered a

Preferred Drug by the Plan. Usually there are lower cost alternatives to some Non-Preferred Brand Drugs.

- 65. **Open Enrollment Period** - Those periods of time agreed to by the Plan and the Group during which eligible Employees and their dependents may enroll as Members.
- 66. **Ophthalmologist** – A person or a doctor of medicine (M.D.) or osteopathy (D.O.) who specializes in the comprehensive care of the eyes and visual system to prevent, diagnose, and treat any eye disease, disorder, or injury.
- 67. **Optician** – One who is licensed to fit, adjust, and dispense eyeglasses and other optical devices on the written prescription of a licensed Ophthalmologist or Optometrist.
- 68. **Optometrist** – A doctor of optometry (O.D.) who is trained to detect and correct vision problems primarily by prescribing eyeglasses or contact lenses.
- 69. **Oral Appliance** – a device placed in the mouth and used to treat mild to moderate obstructive sleep apnea by repositioning or stabilizing the lower jaw, tongue, soft palate or uvula. An Oral Appliance may also be used to treat TMJ or TMD by stabilizing the jaw joint. An Oral Appliance is not the same as an occlusal splint, which is used to treat malocclusion or misalignment of teeth.
- 70. **Out-of-Network Pharmacy** - a Pharmacy that has not entered into a service agreement with BlueCross or its agent to provide benefits under this Rider at specified rates to You.
- 71. **Out-of-Network Provider** – Any Provider who is an Eligible Provider type but who does not have a contract with the Plan to provide Covered Services.
- 72. **Out-of-Pocket Maximum** - The total dollar amount, as stated in Attachment C: Schedule of Benefits that a Member must incur and pay for Covered Services during the Annual Benefit Period, including Copayments, Deductible, and Coinsurance. There are two (2) Out-of-Pocket Maximums – one for services rendered by Network Providers and one for services rendered by Out-of-Network Providers.

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

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

When the Out-of-Network Out-of-Pocket Maximum is reached, benefits are payable at 100% for expenses for other Covered Services from Out-of-Network Providers incurred by the Member during the remainder of that Annual Benefit Period, excluding Penalties and any balance of charges (the difference between Billed Charges and the Maximum Allowable Charge).
- 73. **Oversized Lens** – Any lens with an eye size of 61mm or greater.
- 74. **Payor(s)** - An insurer, health maintenance organization, no-fault liability insurer, self-insured group, or other entity that provides or pays for a Member's health care benefits.
- 75. **Penalty/Penalties** – Additional Member Payments required as a result of failure to comply with Plan requirements such as failing to obtain Prior Authorization for certain Covered Services shown in Attachment C: Schedule of Benefits, as requiring such Prior Authorization. The Penalty will be a reduction in Plan payment for Covered Services.

76. **Periodic Health Screening** – An assessment of a patient’s health status at intervals set forth in the Plan’s Medical Policies, for the purpose of maintaining health and detecting disease in its early state. This assessment should include:
- i. a complete history or interval update of the patient’s history and a review of systems; and
 - ii. a physical examination of all major organ systems, and preventive screening tests per the Plan’s medical policy.
77. **Pharmacy** - a state or federally licensed establishment that is physically separate and apart from the office of a physician or authorized Practitioner, and where Legend Drugs are dispensed by Prescription by a pharmacist licensed to dispense such drugs and products under the laws of the state in which he or she practices.
78. **Pharmacy and Therapeutics Committee or P&T Committee** - A panel of the Plan’s participating pharmacists, Network Providers, medical directors and pharmacy directors that reviews medications for safety, efficacy and cost effectiveness. The P&T Committee evaluates medications for addition and deletion from the: (1) Drug Formulary; (2) Preferred Brand Drug list; (3) Prior Authorization Drug list; and (4) Quantity Limitation list. The P&T Committee may also set dispensing limits on medications.
79. **Practitioner** – A person licensed by the State to provide medical services.
80. **Preferred Brand Drug** - Brand Name Drugs that the Plan has reviewed for clinical appropriateness, safety, therapeutic efficacy, and cost effectiveness. The Preferred Brand Drug list is reviewed at least annually by the P&T Committee.
81. **Preferred Formulary** – A list of specific generic and brand name Prescription Drugs covered by the Plan subject to Quantity Limitations, Prior Authorization and Step Therapy. The Preferred Formulary is subject to periodic review and modification at least annually by the Plan’s Pharmacy and Therapeutics Committee. The Preferred Formulary is available for review at bcbst.com, or by calling the number on the back of Your Member ID card.
82. **Preferred Specialty Pharmacy Network** - a Pharmacy that has entered into a network pharmacy agreement with the Plan or its agent to legally dispense self-administered Specialty Drugs to You.
83. **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.
84. **Prescription Contraceptive Drugs** - Prescription drug products that are indicated for the prevention of pregnancy.
85. **Prescription Drug** - a medication containing at least one Legend Drug that may not be dispensed under applicable state or federal law without a Prescription, and/or insulin.
86. **Premium** – The total payment for Coverage under the Group Agreement, including amounts paid by You and the Group for such Coverage.
87. **Prior Authorization, Authorized** – A review conducted by the Plan, prior to the delivery of certain services, to determine if such services will be considered Covered Services.
88. **Prior Authorization Drugs**- Prescription Drugs that are only eligible for reimbursement after prior authorization from the Plan as determined by the P&T Committee.

89. **Provider** – A person or entity engaged in the delivery of health services who, or that is licensed, certified or practicing in accordance with applicable State or Federal laws.
90. **Qualified Medical Child Support Order** – A medical child support order issued by a court of competent jurisdiction that creates or recognizes the existence of a child's right to receive benefits for which a Subscriber is eligible under the Group Agreement. Such order shall identify the Subscriber and each such child by name and last known mailing address; give a description of the type and duration of coverage to be provided to each child; and identify each health plan to which such order applies.
91. **Quantity Limitation** – Quantity limitations applied to certain Prescription Drug products as determined by the Pharmacy and Therapeutics Committee.
92. **Rider** – An attachment or endorsement to this EOC providing additional or expanded benefits not otherwise Covered by the Plan.
93. **Select90 Network** – BlueCross's network of retail pharmacies that are permitted to dispense Prescription Drugs to BlueCross Members on the same terms as pharmacies in the Mail Order Network.
94. **Specialty Drugs** – Injectable, infusion and select oral medications that require complex care, including special handling, patient education and continuous monitoring. Specialty Drugs are listed on the Plan's Specialty Drug list. Specialty Drugs are categorized as Provider-administered or self-administered.
95. **Standard Lens** – Standard glass or plastic (CR39) in clear or Rose Tint #1 or #2. Any lens that will fit any frame with an eye size less than 61 mm.
96. **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.
97. **Subscriber** – an Employee, who meets all applicable eligibility requirements, has enrolled for Coverage and for whom the Plan has received the applicable Premium for Coverage from the Group.
98. **Surgery or Surgical Procedure** - Medically Necessary and Appropriate surgeries or procedures. Surgeries involve an excision or incision of the body's skin or mucosal tissues, treatment of broken or dislocated bones, and/or insertion of instruments for exploratory or diagnostic purposes into a natural body opening.
99. **Telemedicine**– the use of two-way real time electronic communications and used for medical diagnostic and therapeutic purposes between a Practitioner and a Member from one site to another.
100. **Totally Disabled or Total Disability** – Either: (a) You, if an Employee, are prevented from performing Your work duties and are unable to engage in any work or other gainful activity for which You are qualified or could reasonably become qualified to perform by reason of education, training, or experience because of injury or disease; or (b) You, if a Covered Dependent, are prevented from engaging in substantially all of the normal activities of a person of like age and sex in good health because of non-occupational injury or disease.

101. **Transplant Maximum Allowable Charge (TMAC)** – The amount that the Plan, in its discretion, has determined to be the maximum amount payable for Covered Services for Organ Transplants. Each type of Organ Transplant has a separate TMAC.
102. **Transplant Network** – A network of hospitals and facilities, each of which has agreed to perform specific organ transplants. For example, some hospitals might contract to perform heart transplants, but not liver transplants.
103. **Transplant Network Institution** – A facility or hospital that has contracted with BlueCross (or with an entity on behalf of BlueCross) to provide Transplant Services for some or all organ and bone marrow transplant procedures Covered under this Plan. For example, some hospitals might contract to perform heart transplants, but not liver transplants. A Transplant Network Institution is a Network Provider when performing contracted transplant procedures in accordance with the requirements of this EOC.
104. **Transplant Service** - Medically Necessary and Appropriate Services listed as Covered under the Transplant Service section in Attachment A of this EOC.
105. **Vision Examination** – A comprehensive ophthalmologic service as defined in the Current Procedural Technology (CPT) and the Documentation Guidelines listed under “Eyes – examination items.” Comprehensive ophthalmologic service describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmologic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated, biomicroscopy, examination with cycloplegia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs.
106. **Well Woman Exam** – A routine visit every Annual Benefit Period to a Provider. The visit may include Medically Necessary and Medically Appropriate mammogram and cervical cancer screenings.

EVIDENCE OF COVERAGE

Attachment A: Covered Services and Exclusions

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

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

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

Please also read Attachment B: Other Exclusions.

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

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

Obtaining services not listed as a Covered Service in this Attachment or not in accordance Our medical policy and Care Management procedures may result in the denial of benefits or a reduction in reimbursement for otherwise eligible Covered Services.

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

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

A Clinical Trial is a prospective biomedical or behavioral research study of human subjects that is designed to answer specific questions about biomedical or behavioral interventions (vaccines, drugs, treatments, devices, or new ways of using known drugs, treatments, or devices). Clinical Trials are used to determine whether new biomedical or behavioral interventions are safe, efficacious, and effective.

Routine patient care associated with an approved Clinical Trial will be Covered under the Plan's benefits in accordance with the Plan's medical policies and procedures.

A. Ambulance Services

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

1. Covered Services
 - a. Medically Necessary and Appropriate land or air transportation from the scene of an accident or Emergency to the nearest appropriate hospital.
2. Exclusions
 - a. Transportation for Your convenience.
 - b. Transportation that is not essential to reduce the probability of harm to You.
 - c. Services when You are not transported to a hospital.

B. Behavioral Health

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

1. Prior Authorization is required for:
 - a. All inpatient levels of care, which include Acute care, residential care, and partial hospital care; and intensive outpatient programs.
 - b. Electro-convulsive therapy (ECT), whether performed on an inpatient or outpatient basis.
 - c. Outpatient visits do not require Prior Authorization.

Call the number on the back of Your Member ID card if You have questions about Prior Authorization requirements for Behavioral Health Services.

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

2. Covered Services
 - a. Inpatient and outpatient service for care and treatment of mental health disorders and substance abuse disorders.
 - b. Care Management benefits may be available.
 - c. Outpatient treatment visits for medication management. These visits do not count toward the number of mental health outpatient visits per year. Medication management means pharmacological management, including prescription, use, and review of medication with no more than minimal medical psychotherapy.
3. Exclusions
 - a. Pastoral counseling.

- b. Marriage and family counseling without a behavioral health diagnosis.
- c. Vocational and educational training and/or services.
- d. Custodial or domiciliary care.
- e. Conditions without recognizable ICD-9 diagnostic classification, such as adult child of alcoholics (ACOA), and co-dependency and self-help programs.
- f. Sleep disorders.
- g. Services related to mental retardation.
- h. Court ordered examinations and treatment, unless Medically Necessary.
- i. Pain management.
- j. Hypnosis or regressive hypnotic techniques.

C. Dental Services – Medically Necessary for all Members

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

1. Covered Services

- a. Dental services and oral surgical care to treat intraoral cancer, or to treat accidental injury to the jaw, sound natural teeth, mouth, or face, due to external trauma. The Surgery and services to treat accidental injury must be started within 3 months and completed within 12 months of the accident.
- b. For dental services not listed in subsection a. above, general anesthesia, nursing and related hospital expenses in connection with an inpatient or outpatient dental procedure are Covered, only when one of the 5 conditions listed below is met. Prior Authorization for inpatient services is required.
 - I. Complex oral Surgical Procedures that have a high probability of complications due to the nature of the Surgery;
 - II. Concomitant systemic disease for which the patient is under current medical management and that significantly increases the probability of complications;
 - III. Mental illness or behavioral condition that precludes dental Surgery in the office;
 - IV. Use of general anesthesia and the Member's medical condition requires that such procedure be performed in a Hospital; or
 - V. Dental treatment or Surgery performed on a Member 8 years of age or younger, where such procedure cannot be safely provided in a dental office setting.
- c. Oral Appliances to treat obstructive sleep apnea, if Medically Necessary.

2. Exclusions

- a. Routine dental care and related services including, but not limited to: (1) crowns; (2) caps; (3) plates; (4) bridges; (5) dental x-rays; (6) fillings; (7) tooth extraction, except as listed above; (8) periodontal Surgery; (9) root canals; (10) preventive care (cleanings, x-rays); (11)

replacement of teeth (including implants, false teeth, bridges); (12) bone grafts (alveolar Surgery); (13) treatment of injuries caused by biting and chewing; (14) treatment of teeth roots; and (15) treatment of gums surrounding the teeth.

- b. Treatment for correction of underbite, overbite, and misalignment of the teeth including but not limited to, braces for dental indications, orthognathic Surgery, and occlusal splints and occlusal appliances to treat malocclusion/misalignment of teeth.
- c. Extraction of impacted teeth, including wisdom teeth. However, if both Your medical and dental plans are insured through BlueCross under the same group number, this medical plan will pay secondary benefits for extraction of impacted teeth after Your BlueCross dental plan has paid its benefits.

D. Dental Services - Orthodontia - Pediatric Only

Orthodontia when performed in conjunction with Medically Necessary and Appropriate orthognathic Surgery for Members under age 19. Prior Authorization for Medically Necessary orthodontia must be obtained from the Plan, or benefits will be reduced or denied.

- 1. Covered
 - a. Medically Necessary and Appropriate non-cosmetic orthodontia when performed in conjunction with orthognathic Surgery for members under age 19.
- 2. Exclusions
 - a. Orthodontia for members over age 19.
 - b. Cosmetic orthodontia.

E. Dental Services – Pediatric Dental

This Pediatric Dental section provides a wide range of benefits to Cover most services associated with dental care for dependents under age 19.

If a Member transfers from the care of one Dentist to another during the course of treatment, or if more than one Dentist renders services for one dental procedure, benefits will not exceed those that would have been provided had one Dentist rendered the service.

When more than one treatment alternative exists, meets generally accepted standards of professional dental care, and offers a favorable prognosis for Your condition, We reserve the right to provide payment for the least expensive Covered Service alternative.

I. Diagnostic Services

A. Exams

- 1. Covered
 - a. Standard exams including comprehensive, periodic, detailed/extensive limited and periodontal oral evaluations (exams).
- 2. Limitations
 - a. No more than one standard exam in any 6 month period.
- 3. Exclusions
 - a. Re-evaluations and consultations.

B. X-rays

1. Covered
 - a. Full mouth series, intraoral and bitewing radiographs (x-rays).
2. Limitations
 - a. No more than one full mouth set of x-rays in any 60 month period. A full mouth set of x-rays is defined as either an intraoral complete series or panoramic x-ray. Benefits provided for either include benefits for all necessary intraoral and bitewing films taken on the same day.
 - b. No more than four bitewing films in any 6 month period. Bitewing films must be taken on the same date of service.
3. Exclusions
 - a. Extraoral, skull and bone survey, sialography, and tomographic survey x-ray films, cephalometric films and diagnostic photographs.

II. Preventive Services

A. Prophylaxis (Cleanings)

1. Covered
 - a. Child prophylaxis (cleaning) for primary and permanent teeth.
2. Limitations
 - a. No more than one of any prophylaxis or periodontal maintenance procedure in any 6 month period.
 - b. Periodontal maintenance procedures are subject to additional limitations listed below under Basic Periodontics, and may be subject to a different Coverage level under Attachment C: Schedule of Benefits.

B. Fluoride Treatment

1. Covered
 - a. Topical fluoride treatments, performed with or without a prophylaxis.
2. Limitations
 - a. No more than one fluoride treatment in any 6 month period.
 - b. Fluoride must be applied separately from prophylaxis paste.

C. Other Preventive Services

1. Covered
 - a. Sealants, preventive resin restorations, space maintainers.
 - b. Palliative (emergency) treatment for the relief of pain.
2. Limitations
 - a. No more than 1 sealant, preventive resin restoration, or resin infiltration per first or second molar tooth per 36 months. Resin infiltrations are subject to a different Coverage level under Attachment C: Schedule of Benefits.

- b. No more than one re-cementation in any 12 month period.
- 3. Exclusions
 - a. Nutritional and tobacco counseling, oral hygiene instructions provided by a Dentist.

III. Basic Restorative Services

A. Fillings and Stainless Steel Crowns

- 1. Covered
 - a. Amalgam restorations (silver fillings), resin composite restorations (tooth colored fillings), resin infiltrations, stainless steel crowns.
- 2. Limitations
 - a. No more than one amalgam or resin restoration per tooth surface in any 12 month period.
 - b. Replacement of existing amalgam and resin composite restorations Covered only after 12 months from the date of initial restoration.
 - c. Replacement of stainless steel crowns Covered only after 60 months from the date of initial restoration.
 - d. No more than 1 sealant, preventive resin restoration, or resin infiltration per first or second molar tooth per 36 months. (Sealant/Preventive resins are subject to additional limitations listed under Preventive Services, and may be subject to a different Coverage level under Attachment C: Schedule of Benefits.)
- 3. Exclusions
 - a. Gold foil restorations.

B. Other Basic Restorative Services

- 1. Covered
 - a. Repair of full and partial dentures and bridges
 - b. Crown and Inlay re-cementation.
 - c. Denture services including adjustments, relining, rebasing and tissue conditioning.
 - d. General anesthesia and IV sedation only when administered by a properly licensed Dentist in a dental office in conjunction with covered surgery procedures or when necessary due to concurrent medical conditions.
- 2. Limitations
 - a. No more than one repair per denture per 24 months.
 - b. Denture adjustments are Covered separately from the denture only after 6 months from the date of initial placement.
 - c. No more than one denture reline or rebase in any 36 month period.

IV. Major Restorative & Prosthodontic Services

A. Single Tooth Restorations

1. Covered
 - a. Crowns (resin, porcelain, $\frac{3}{4}$ cast, and full cast), inlays and onlays (metallic, resin and porcelain), and veneers.
2. Limitations
 - a. Only for the treatment of severe carious lesions or severe fracture on permanent teeth, and only when teeth cannot be adequately restored with an amalgam or resin composite restoration (filling).
 - b. For permanent teeth only.
 - c. Replacement of single tooth restorations or fixed partial dentures. Covered only after 60 months from the date of initial placement.
3. Exclusions
 - a. Temporary and provisional crowns.

B. Multiple Tooth Restorations – Bridges

1. Covered
 - a. Fixed partial dentures (bridges), including pontics, retainers, and abutment crowns, inlays, and onlays (resin, porcelain, $\frac{3}{4}$ and full cast).
2. Limitations
 - a. Only for treatment where a missing tooth or teeth cannot be adequately restored with a removable partial denture.
 - b. For permanent teeth only.
 - c. Replacement of fixed partial dentures or single tooth restorations. Covered only after 60 months from the date of initial placement.
3. Exclusions
 - a. Interim pontic and retainer crowns.

C. Removable Prosthodontics (Dentures)

1. Covered
 - a. Complete, immediate and partial dentures.
2. Limitations
 - a. If, in the construction of a denture, the Member and the Dentist decide on a personalized restoration or to employ special rather than standard techniques or materials, benefits provided shall be limited to those which would otherwise be provided for the standard procedures or materials (as determined by the Plan).
 - b. for permanent teeth only.
 - c. Replacement of removable dentures Covered only after 60 months from the date of initial placement.

3. Exclusions
 - a. Interim (temporary) dentures.

D. Other Major Restorative & Prosthodontic Services

1. Covered
 - a. Crown and bridge services including core buildups, post and core, and repair.
 - b. Implants and Implant supported prosthetics, including local anesthetic.
2. Limitations
 - a. The benefits provided for crown and bridge restorations include benefits for the services of crown preparation, temporary or prefabricated crowns, impressions and cementation.
 - b. Benefits will not be provided for a core build-up separate from those provided for crown construction, except in those circumstances where benefits are provided for a crown because of severe carious lesions or fracture is so extensive that retention of the crown would not be possible.
 - c. Post and core services are Covered only when performed in conjunction with a Covered crown or bridge.
 - d. Crown, inlay, onlay, and veneer repair are Covered separately only after 12 months from the date of initial placement.
 - e. Implant limited to one per tooth per 60 months.
 - f. Bone graft for implant is covered if implant is covered.
 - g. Implant debridement is limited to one per tooth per 60 months and is covered if implant is covered.
 - h. Replacement of implant supported prosthesis is covered only after 60 months from the date of any prosthesis placement.
3. Exclusions
 - a. Other major restorative services including protective restoration and coping.
 - b. Other prosthodontic services including overdenture, precision attachments, connector bars, stress breakers and coping metal.
 - c. Temporary and interim implant abutment.

V. Endodontics (treatment of the dental pulp or root canal)

A. Basic Endodontics

1. Covered
 - a. Pulpotomy, pulpal therapy.
2. Limitations
 - a. For primary teeth only.
 - b. Not Covered when performed in conjunction with major endodontic treatment.

- c. The benefits for basic endodontic treatment include benefits for x-rays, pulp vitality tests, and protective restoration provided in conjunction with basic endodontic treatment. However, pulp vitality tests and protective restorations are not Covered when billed separately from other endodontic services.

- 3. Exclusions

- a. Pulpal debridement.

- B. Major Endodontics**

- 1. Covered Services

- a. Root canal treatment and re-treatment, apexification, pulpal regeneration, apicoectomy services, root amputation, retrograde filling, hemisection, pulp cap.

- 2. Limitations

- a. The benefits for major endodontic treatment include benefits for x-rays, pulp vitality tests, pulpotomy, pulpectomy and protective restoration and temporary filling material provided in conjunction with major endodontic treatment. However, pulp vitality tests and protective restorations are not Covered when billed separately from other endodontic services.

- 3. Exclusions

- a. Implantation, canal preparation, and incomplete endodontic therapy.

- VI. Periodontics**

- A. Basic Periodontics**

- 1. Covered

- a. Non-surgical periodontics, including periodontal scaling and root planing, full mouth debridement and periodontal maintenance procedure.

- 2. Limitations

- a. No more than one periodontal scaling and root planing per quadrant in any 24 month period.
 - b. No more than one full mouth debridement per lifetime.
 - c. No more than four of any prophylaxis (cleanings) or periodontal maintenance procedure in any 12 month period. Cleanings are subject to additional limitations listed under Preventive Services, and may be subject to a different Coverage level under Attachment C: Schedule of Benefits.
 - d. Benefits for periodontal maintenance are provided only after active periodontal treatment (surgical or non-surgical), and no sooner than 90 days after completion of such treatment.
 - e. Benefits for periodontal scaling and root planing, full mouth debridement, periodontal maintenance and prophylaxis are not provided when more than one of these procedures is performed on the same day.

3. Exclusions

- a. Provisional splinting, scaling in the presence of gingival inflammation, antimicrobial medication and dressing changes.

B. Major Periodontics

1. Covered

- a. Surgical periodontics including gingivectomy, gingivoplasty, gingival flap procedure, crown lengthening, osseous surgery and bone and tissue grafting.
- b. Benefits provided for major periodontics include benefits for services related to 90 days of postoperative care.

2. Limitations

- a. No more than one major periodontal surgical procedure in any 36 month period.

3. Exclusions

- a. Tissue regeneration and apically positioned flap procedure.

VII. Oral Surgery

A. Basic Oral Surgery

1. Covered

- a. Non-surgical or simple extractions.

2. Limitations

- a. Benefits provided for basic oral surgery include benefits for suturing and postoperative care.

3. Exclusions

- a. Benefits for general anesthesia or intravenous sedation when performed in conjunction with basic oral surgery.

B. Major Oral Surgery

1. Covered

- a. Surgical extractions (including removal of impacted teeth), coronectomy, and other oral surgical procedures typically not Covered under a medical plan.
- b. Benefits provided for major oral surgery include benefits for local anesthesia, suturing and postoperative care.

2. Limitations

- a. Benefits for general anesthesia or intravenous (IV) sedation are provided only in connection with major oral surgery procedures, and only when provided by a Dentist licensed to administer such agents.

3. Exclusion

- a. Oral surgery typically Covered under a medical plan, including but not limited to, excision of lesions and bone tissue, treatment of fractures, suturing, wound and other repair procedures and related procedures.
- b. Harvesting of bone for use in autogenous grafting.

VIII. General Pediatric Dental Exclusions

Pediatric Dental Coverage does not provide benefits for the following services, supplies or charges:

- a. Services rendered by a Dentist beyond the scope of his or her license.
- b. Dental services which are free, or for which You are not required or legally obligated to pay or for which no charge would be made if You had no dental Coverage.
- c. Dental services covered by any medical insurance coverage, or by any other non-dental contract or certificate issued by BlueCross BlueShield of Tennessee or any other insurance company, carrier, or plan. For example, removal of impacted teeth, tumors of lip and gum, accidental injuries to the teeth, etc.
- d. Dental care or treatment not specifically listed in Attachment C: Schedule of Benefits.
- e. Any treatment or service that the Plan determines is not Necessary Dental Care that does not offer a favorable prognosis that does not meet generally accepted standards of professional dental care, or that is experimental in nature.
- f. Charges for any hospital or other surgical or treatment facility and any additional fees charged by a Dentist for treatment in any such facility.
- g. Dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes including cosmetic orthodontia.
- h. Replacement of tooth structure lost from wear or attrition.
- i. Dental services resulting from loss or theft of a denture, crown, bridge or removable orthodontic appliance.
- j. Charges for a prosthetic device that replaces one or more lost, extracted or congenitally missing teeth before Your Coverage becomes effective under the Plan unless it also replaces one or more natural teeth extracted or lost after Your Coverage became effective.
- k. Diagnosis for, or fabrication of, adjustment or maintenance and cleaning of maxillofacial prosthesis, appliances or restorations necessary to correct bite problems or restore the occlusion.
- l. Diagnostic dental services such as diagnostic tests and oral pathology services.
- m. Adjunctive dental services including all local and general anesthesia, sedation, and analgesia (except as provided under a covered surgery).
- n. Charges for the treatment of desensitizing medicaments, drugs, occlusal guards and adjustments, mouthguards, microabrasion, behavior management, and bleaching.
- o. Charges for the treatment of professional visits outside the dental office or after regularly scheduled hours or for observation.

p. Charges for the inhalation of nitrous oxide/analgesia, anxiolysis.

F. Dental – Temporomandibular Joint Dysfunction (TMJ) for all Members

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

1. Covered Services

- a. Diagnosis and management of TMJ or TMD.
- b. Surgical treatment of TMJ or TMD, if performed by a qualified oral surgeon or maxillofacial surgeon.
- c. Non-surgical TMJ includes: (1) history and exam; (2) office visit; (3) x-rays; (4) diagnostic study casts; (5) medications; and (6) Oral Appliances to stabilize jaw joint.

2. Exclusions

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

G. Diabetes Treatment

Medically Necessary and Appropriate diagnosis and treatment of diabetes. In order to be Covered, such services must be prescribed and certified by a Practitioner as Medically Necessary. The treatment of diabetes consists of medical equipment, supplies, and outpatient self-management training and education, including nutritional counseling. See Pharmacy Prescription Drug Program for additional Diabetic benefits.

1. Covered Services

- a. Insulin pumps, infusion devices, and appurtenances. Insulin pump replacement is Covered only for pumps older than 48 months and if the pump cannot be repaired;
- b. Podiatric appliances for prevention of complications associated with diabetes.

2. Exclusions

- a. Treatments or supplies that are not prescribed and certified by a Practitioner as being Medically Necessary.
- b. Items not identified in the Mandated Diabetes Supplies List.

H. Diagnostic Services

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

1. Covered Services
 - a. Imaging services ordered by a Practitioner, including x-ray, ultrasound, bone density test, and Advanced Radiological Imaging Services. Advanced Radiological Imaging Services include MRIs, CT scans, PET scans, and nuclear cardiac imaging.
 - b. Diagnostic laboratory services ordered by a Practitioner.
2. Exclusions
 - a. Diagnostic Services that are not Medically Necessary and Appropriate.
 - b. Diagnostic Services not ordered by a Practitioner.

I. Durable Medical Equipment (DME)

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

1. Covered Services
 - a. Rental of durable medical equipment - Maximum allowable rental charge not to exceed the total Maximum Allowable Charge for purchase. If You rent the same type of equipment from multiple DME Providers, and the total rental charges from the multiple Providers exceed the purchase price of a single piece of equipment, You will be responsible for amounts in excess of the Maximum Allowable Charge for purchase.
 - b. The repair, adjustment or replacement of components and accessories necessary for the effective functioning of Covered equipment.
 - c. Supplies and accessories necessary for the effective functioning of Covered durable medical equipment.
 - d. The replacement of items needed as the result of normal wear and tear, defects or obsolescence and aging. Insulin pump replacement is Covered only for pumps older than 48 months and only if the pump cannot be repaired.
2. Exclusions
 - a. Charges exceeding the total cost of the Maximum Allowable Charge to purchase the equipment.
 - b. Unnecessary repair, adjustment or replacement or duplicates of any such equipment.
 - c. Supplies and accessories that are not necessary for the effective functioning of the Covered equipment.
 - d. Items to replace those that were lost, damaged, stolen or prescribed as a result of new technology.
 - e. Items that require or are dependent on alteration of home, workplace or transportation vehicle.
 - f. Motorized scooters, exercise equipment, hot tubs, pool, and saunas.

- g. “Deluxe” or “enhanced” equipment. The most basic equipment that will provide the needed medical care will determine the benefit.
- h. Computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, and seat lifts of any kind.
- i. Patient lifts, auto tilt chairs, air fluidized beds, or air flotation beds, unless approved by Case Management for a Member who is in Case Management.
- j. Portable ramp for a wheelchair.

J. Emergency Care Services

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

1. Covered Services

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

An observation stay that occurs in conjunction with an ER visit will be subject to member cost share under the Outpatient Facility Services section in addition to member cost share for the ER visit.

2. Exclusions

- a. Treatment of a chronic, non-Emergency condition, where the symptoms have existed over a period of time, and a prudent layperson who possesses an average knowledge of health and medicine would not believe it to be an Emergency.
- b. Services received for inpatient care or transfer to another facility once Your medical condition has stabilized, unless Prior Authorization is obtained from the Plan within 24 hours or the next working day.

K. Family Planning and Reproductive Services

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

1. Covered Services

- a. Benefits for: (1) family planning; (2) history; (3) physical examination; (4) diagnostic testing; and (5) genetic testing.
- b. Sterilization procedures.
- c. Services or supplies for the evaluation of infertility.
- d. Medically Necessary and Appropriate termination of a pregnancy.
- e. Injectable and implantable hormonal contraceptives and vaginal barrier methods including initial fitting, insertion and removal.

2. Exclusions

- a. Services or supplies that are designed to create a pregnancy, enhance fertility or improve conception quality, including but not limited to: (1) artificial insemination; (2)

in vitro fertilization; (3) fallopian tube reconstruction; (4) uterine reconstruction; (5) assisted reproductive technology (ART) including but not limited to GIFT and ZIFT; (6) fertility injections; (7) fertility drugs; (8) services for follow-up care related to infertility treatments.

- b. Services or supplies for the reversals of sterilizations.
- c. Induced abortion unless: (1) the health care Practitioner certifies in writing that the pregnancy would endanger the life of the mother, or; (2) the pregnancy is a result of rape or incest.

L. Home Health Care Services

Medically Necessary and Appropriate services and supplies provided in Your home by a Practitioner who is primarily engaged in providing home health care services. Home visits by a skilled nurse require Prior Authorization. Physical, speech or occupational therapy provided in the home does not require Prior Authorization, but does apply to the Therapy Services visit limits shown in Attachment C: Schedule of Benefits.

1. Covered Services

- a. Part-time, intermittent health services, supplies, and medications, by or under the supervision of a registered nurse.
- b. Home infusion therapy.
- c. Rehabilitative therapies such as physical therapy, occupational therapy, etc. (subject to the limitations of the Therapeutic/Rehabilitative/Habilitative benefit.)
- d. Medical social services.
- e. Dietary guidance.
- f. Coverage is limited as indicated in Attachment C: Schedule of Benefits.

2. Exclusions

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

M. Hospice

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

1. Covered Services

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

2. Exclusions

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

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

N. Inpatient Hospital Services

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

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

1. Covered Services

- a. Room and board in a semi-private room (or private room if room and board charges are the same as for a semi-private room); general nursing care; medications, injections, diagnostic services and special care units.
- b. Attending Practitioner's services for professional care.
- c. Maternity and delivery services (including routine nursery care and Complications of Pregnancy). If the hospital or physician provides services to the baby and submits a claim in the baby's name, benefits may be Covered for the baby and mother as separate Members, requiring payment of applicable Member Copayments and/or Deductibles.

2. Exclusions

- a. Inpatient stays primarily for therapy (such as physical or occupational therapy).
- b. Private duty nursing.
- c. Services that could be provided in a less intensive setting.
- d. Private room when not Authorized by the Plan and room and board charges are in excess of semi-private room.
- e. Blood or plasma provided at no charge to the patient.

O. Organ Transplants

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

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

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

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

1. Prior Authorization Procedures

To obtain Prior Authorization, You or Your Practitioner must contact the Plan's Transplant Case Management department before pre-transplant evaluation or Transplant Services are received. Authorization should be obtained as soon as possible after You have been identified as a possible candidate for Transplant Services.

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

2. Covered Services

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

- a. Medically Necessary and Appropriate services and supplies, otherwise Covered under this EOC;
- b. Medically Necessary and Appropriate services and supplies for each listed organ transplant are Covered only when Transplant Case Management approves a transplant. **Not all Network Providers are in Our Transplant Network. Please check with a Transplant case manager to see which Hospitals are in Our Transplant Network , or check on Our website: bcbst.com;**
- c. Travel expenses for Your evaluation prior to a Covered Procedure, and to and from the site of a Covered Procedure by: (1) private car; (2) ground or air ambulance; or (3) public transportation. This includes travel expenses for You and a companion. A companion must be Your spouse, family member, Your guardian or other person approved by Transplant Case Management. In order to be reimbursed, travel must be approved by Transplant Case Management. In many cases, travel will not be approved for kidney transplants.
 - I. Travel by private car is limited to reimbursement at the IRS mileage rate in effect at the time of travel to and from a facility in the Transplant Network.
 - II. Meals and lodging expenses are Covered, limited to \$150 daily.
 - III. The aggregate limit for travel expenses is \$10,000 per Covered Procedure.
 - IV. Travel Expenses are Covered only if You go to a Transplant Network Institution;
- d. Donor Organ Procurement. If the donor is not a Member, Covered Services for the donor are limited to those services and supplies directly related to the Transplant Service itself: (1) testing for the donor's compatibility; (2) removal of the organ from donor's body; (3) preservation of the organ; (4) transportation of the organ to the site of transplant; and (5) donor follow-up care. Services are Covered only to the extent not covered by other health coverage. The search process and securing the organ are also Covered under this benefit.

Complications of donor organ procurement are not Covered The cost of Donor Organ Procurement is included in the total cost of Your Organ Transplant.

3. Conditions/Limitations

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

- a. You or Your Practitioner must notify Transplant Case Management prior to Your receiving any Transplant Service, including pre-transplant evaluation, and obtain Prior Authorization. If Transplant Case Management is not notified, the transplant and related procedures will not be Covered at all;
- b. Transplant Case Management will coordinate all Transplant Services, including pre-transplant evaluation. You must cooperate with Us in coordination of these services;
- c. Failure to notify Us of proposed Transplant Services, or to coordinate all transplant related services with Us, will result in the reduction or exclusion of payment for those services;
- d. You must go through Transplant Case Management and receive Prior Authorization for Your transplant to be Covered;
- e. Once You have notified Transplant Case Management and received Prior Authorization, You may decide to have the transplant performed outside the Transplant Network. **However, Your benefits will be greatly limited, as described below. Only the Transplant Maximum Allowable Charge for the Service provided will be Covered;**
 - I. Transplant Network transplants. You have the transplant performed at a Transplant Network Provider. You receive the highest level of reimbursement for Covered Services. The Plan will reimburse the Transplant Network Provider at the benefit level listed in Attachment C: Schedule of Benefits, at the Transplant Maximum Allowable Charge. The Transplant Network Provider cannot bill You for any amount over the Transplant Maximum Allowable Charge for the transplant, which limits Your liability;
 - II. Network transplants. You have the transplant performed outside the Transplant Network, but still at a facility that is a Network Provider or a BlueCard PPO Participating Provider. The Plan will reimburse the Network or BlueCard PPO Participating Provider at the benefit level listed in Attachment C: Schedule of Benefits, limited to the Transplant Maximum Allowable Charge. There is no maximum to Your liability. The Provider also has the right to bill You for any amount not Covered by the Plan – this amount may be substantial;
 - III. Out-of-Network transplants. You have the transplant performed by an Out-of-Network Provider (i.e., outside the Transplant Network, and not at a facility that is a Network Provider or a BlueCard PPO Participating Provider). The Plan will reimburse the Out-of-Network Provider only at the benefit level listed in Attachment C: Schedule of Benefits, limited to the Transplant Maximum Allowable Charge. There is no maximum to Your liability. **The Out-of-Network Provider also has the right to bill You for any amount not Covered by the Plan - this amount may be substantial;**

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

- f. Kidney transplants. There are two levels of benefits for kidney transplants: In-Network and Out-of-Network:
 - I. Network kidney transplants. You have a kidney transplant performed at a facility that is a Network Provider or a BlueCard PPO Participating Provider. You receive the highest level of reimbursement for Covered Services. The Network or BlueCard PPO Participating Provider cannot bill You for any amount over the Maximum Allowable Charge for the transplant, which limits Your liability;
 - II. Out-of-Network kidney transplants. You have a kidney transplant performed by an Out-of-Network Provider (i.e. not at a facility that is a Network Provider or a BlueCard PPO Participating Provider). The Plan will reimburse the Out-of-Network Provider only at the benefit level listed in Attachment C: Schedule of Benefits, at the Maximum Allowable Charge. There is no maximum to Your liability. **The Out-of-Network Provider also has the right to bill You for any amount not Covered by the Plan; this amount may be substantial;**
- g. If You go through Transplant Case Management for Your transplant, follow its procedures, cooperate fully with them, and have Your transplant performed at a Transplant Network Institution, the transplant expenses specified in Attachment C: Schedule of Benefits, are Covered.

4. Exclusions

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

- a. Transplant and related services that did not receive Prior Authorization;
- b. Any service specifically excluded under Attachment B, Other Exclusions, except as otherwise provided in this section;
- c. Services or supplies not specified as Covered Services under this section;
- d. Any attempted Covered Procedure that was not performed, except where such failure is beyond Your control;
- e. Non-Covered Services;
- f. Services that would be covered by any private or public research fund, regardless of whether You applied for or received amounts from such fund;
- g. Any non-human, artificial or mechanical organ;
- h. Payment to an organ donor or the donor's family as compensation for an organ, or payment required to obtain written consent to donate an organ;
- i. Donor services including screening and assessment procedures that have not received Prior Authorization from Us;
- j. Removal of an organ from a Member for purposes of transplantation into another person, except as Covered by the Donor Organ Procurement provision as described above;
- k. Harvest, procurement, and storage of stem cells, whether obtained from peripheral blood, cord blood, or bone marrow when reinfusion is not scheduled or anticipated to be scheduled within an appropriate time frame for the patient's covered stem cell transplant diagnosis.

- 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.

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

P. Outpatient Facility Services

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

1. Covered Services
 - a. Practitioner services.
 - b. Outpatient diagnostics (such as x-rays and laboratory services).
 - c. Outpatient treatments (such as medications and injections).
 - d. Outpatient Surgery and supplies.
 - e. Observation stays less than 24 hours.
 - f. Telemedicine.
2. Exclusions
 - a. Rehabilitative therapies in excess of the terms of the Therapeutic/Rehabilitative/Habilitative benefit.
 - b. Services that could be provided in a less intensive setting.

Q. Pharmacy Prescription Drug Program for retail and mail order Prescriptions

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

1. Covered Services
 - a. This EOC covers the following at 100%, in accordance with the Women's Preventive Services provision of the Affordable Care Act:
 - I. Generic contraceptives;
 - II. vaginal ring;
 - III. hormonal patch;
 - IV. and Emergency contraception available with a Prescription.
 - V. Brand name Prescription Contraceptive Drugs are Covered as any other Prescription, if a Generic Drug equivalent is available. See Attachment C: Schedule of Benefits.
 - b. Prescription Drugs and items listed in the Mandated Diabetes Supplies List.
 - c. Prescription Drugs must be:
 - I. prescribed on or after Your Coverage begins;

- II. approved for use by the Food and Drug Administration (FDA);
- III. dispensed by a licensed pharmacist or network physician;
- IV. listed on the Preferred Formulary.
- d. Treatment of phenylketonuria (PKU), including special dietary formulas while under the supervision of a Practitioner.
- e. Medically Necessary Prescription Drugs used during the induction or stabilization/dose-reduction phases of chemical dependency treatment.
- f. Drugs with a Prescription that are listed with an A or B recommendation by the United States Preventive Services Task Force (USPSTF).
- g. Immunizations administered at a Network Pharmacy.

2. Limitations

- a. Refills must be dispensed pursuant to a Prescription. If the number of refills is not specified in the Prescription, benefits for refills will not be provided beyond one year from the date of the original Prescription.
- b. The Plan has time limits on how soon a Prescription can be refilled. If You request a refill too soon, the Network Pharmacy will advise You when Your Prescription benefit will Cover the refill.
- c. 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.
- d. 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.
- e. Injectable drugs, are Covered only when: (1) intended for self-administration; or (2) defined by the Plan.
- f. Compound Drugs are only Covered when filled or refilled at a Network Pharmacy. The Network Pharmacy must submit the claim through the Plan's pharmacy benefit manager. The claim must contain a valid national drug code (NDC) number for all ingredients in the Compound Drug. The Compound Drug claim will apply the Non-Preferred Brand Drug copayment/coinsurance.
- g. Prescription Drugs that are commercially packaged or commonly dispensed in quantities less than a 30 calendar day supply (e.g. prescription items that are dispensed based on a certain quantity for a therapeutic regimen) will be subject to one Drug Copayment, provided the quantity does not exceed the FDA approved dosage for four calendar weeks.

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.

3. Exclusions

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

- a. drugs that are prescribed, dispensed or intended for use while You are confined in a hospital, skilled nursing facility or similar facility, except as otherwise Covered in the EOC;
- b. any drugs, medications, Prescription devices, dietary supplements or vitamins, available over-the-counter that do not require a Prescription by Federal or State law; and/or Prescription Drugs dispensed in a doctor's office, except as otherwise Covered in the EOC;
- c. any Prescription Drug purchased outside the United States, except those authorized by Us;
- d. any Prescription dispensed by or through a non-retail internet Pharmacy;
- e. medications intended to terminate a pregnancy;
- f. non-medical supplies or substances, including support garments, regardless of their intended use;
- g. artificial appliances;
- h. allergen extracts;
- i. Prescription Drugs You are entitled to receive without charge in accordance with any worker's compensation laws or any municipal, state, or federal program;
- j. replacement Prescriptions resulting from lost, spilled, stolen, or misplaced medications (except as required by applicable law);
- k. drugs dispensed by a Provider other than a Pharmacy or dispensing physician;
- l. administration or injection of any drugs;
- m. Prescription Drugs used for the treatment of infertility;
- n. Prescription Drugs not on the Preferred Formulary;
- o. anorectics (any drug or medicine for the purpose of weight loss and appetite suppression);
- p. all newly FDA approved drugs prior to review by the Plan's P & T Committee. Prescription Drugs that represent an advance over available therapy according to the P & T Committee will be reviewed within at least six (6) months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug, will be reviewed within at least twelve (12) months after FDA approval;
- q. 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;

- r. Prescription Drugs used for cosmetic purposes including, but not limited to: (1) drugs used to reduce wrinkles; (2) drugs to promote hair-growth; (3) drugs used to control perspiration; (4) drugs to remove hair; and (5) fade cream products;
- s. Prescription Drugs used during the maintenance phase of chemical dependency treatment, unless Authorized by Us;
- t. FDA approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia;
- u. Specialty Drugs filled or refilled at a Pharmacy not participating in the Preferred Specialty Pharmacy Network;
- v. drugs used to enhance athletic performance;
- w. Experimental and/or Investigational Drugs .

GENERIC DRUGS

Prescription drugs are classified as brand or generic. A given drug can change from brand to generic or from generic to brand. Sometimes a given drug is no longer available as a Generic Drug. These changes can occur without notice. If You have any questions, please contact Our consumer advisors by calling the number on the back of Your Member ID card.

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

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

R. Pharmacy Prescription Drug Program for Self-Administered Specialty Drugs

Medically Necessary and Appropriate Specialty Drugs for the treatment of disease, administered by a Practitioner or home health care agency and listed as a self-administered drug on the Plan's Specialty Drug list. Certain Specialty Drugs require Prior Authorization from the Plan, or benefits will be reduced or denied. Call Our consumer advisors at the number on the back of Your Member ID card or check Our website, bcbst.com, to find out which Specialty Drugs require Prior Authorization.

1. Covered Services

- a. Self-administered Specialty Drugs. Only those drugs listed as self-administered Specialty Drugs are Covered under this benefit.

2. Exclusions

- a. Provider-administered Specialty Drugs as identified on the Plan's formulary. Refer to section V. Provider-Administered Specialty Drugs for benefit coverage information.
- 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.

Specialty Drugs You have a distinct network for Specialty Drugs: the Preferred Specialty Pharmacy Network. To receive benefits for self-administered Specialty Drugs, You must use a Preferred Specialty Pharmacy Network provider.

S. Practitioner Office Services

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

1. Covered Services

- a. Diagnosis and treatment of illness or injury. (Note that allergy skin testing is covered only in the Practitioner office setting. Medically Necessary RAST (radioallergosorbent test), FAST (fluorescent allergosorbent test), or MAST (multiple radioallergosorbent test) is Covered in the practitioner office setting and in a licensed laboratory.)
- b. Injections and medications administered in a Practitioner's office, except Specialty Drugs. (See Provider Administered Specialty Drugs section for information on Coverage).
- c. Second surgical opinions given by a Practitioner who is not in the same medical group as the Practitioner who initially recommended Surgery.
- d. Preventive/Well Care Services.
 - i. Preventive health exam for adults and children and related services as outlined below and performed by the physician during the preventive health exam or referred by the physician as appropriate, including:
 - Screenings and counseling services with an A or B recommendation by the United States Preventive Services Task Force (USPSTF)
 - Bright Futures recommendations for infants, children and adolescents supported by the Health Resources and Services Administration (HRSA)
 - Preventive care and screening for women as provided in the guidelines supported by HRSA, and
 - Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC).

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

- Annual Well Woman Exam, including cervical cancer screening, screening mammography at age 40 and older, and other USPSTF screenings with an A or B rating.
- Colorectal cancer screening for members age 50-75.
- Prostate cancer screening for men age 50 and older.
- Screening and counseling in the primary care setting for alcohol misuse and tobacco use.

- Dietary counseling for adults with hyperlipidemia, hypertension, Type 2 diabetes, obesity, coronary artery disease and congestive heart failure.
- FDA-approved contraceptive methods, sterilization procedures and counseling for women with reproductive capacity. Note that prescription contraceptive products are covered under the Pharmacy Prescription Drug Program section.
- HPV testing once every 3 years for women age 30 and older.
- Lactation counseling by a trained provider during pregnancy or in the post-partum period, and manual breast pump.

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

2. Exclusions

- a. Office visits, physical exams and related immunizations and tests, when required solely for: (1) sports; (2) camp; (3) employment; (4) travel; (5) insurance; (6) marriage or legal proceedings.
- b. Routine foot care for the treatment of: (1) flat feet; (2) corns; (3) bunions; (4) calluses; (5) toenails; (6) fallen arches; and (7) weak feet or chronic foot strain.
- c. Rehabilitative therapies in excess of the limitations of the Therapeutic/Rehabilitative/Habilitative benefit.
- d. Dental procedures, except as otherwise indicated in this EOC.

T. Prosthetics/Orthotics

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

1. Covered Services

- a. The initial purchase of surgically implanted prosthetic or orthotic devices.
- b. The repair, adjustment or replacement of components and accessories necessary for the effective functioning of Covered equipment.
- c. Splints and braces that are custom made or molded, and are incidental to a Practitioner's services or on a Practitioner's order.
- d. The replacement of Covered items required as a result of normal wear and tear, defects or obsolescence and aging.
- e. The initial purchase of artificial limbs or eyes,
- f. The first set of eyeglasses or contact lenses required to adjust for vision changes due to cataract Surgery and obtained within 6 months following the Surgery.
- g. Hearing aids for Members under age 18, limited as indicated in Attachment C: Schedule of Benefits.

2. Exclusions

- a. Hearing aids for Members age 18 or older.

- b. Prosthetics primarily for cosmetic purposes, including but not limited to wigs, or other hair prosthesis or transplants.
- c. Items to replace those that were lost, damaged, stolen or prescribed as a result of new technology.
- d. The replacement of contacts after the initial pair have been provided following cataract Surgery.
- e. Foot orthotics, shoe inserts and custom made shoes except as required by law for diabetic patients or as a part of a leg brace.

U. Provider-Administered Specialty Drugs

Medically Necessary and Appropriate Specialty Drugs for the treatment of disease, administered by a Practitioner or home health care agency and listed as a provider-administered drug on the Plan's Specialty Drug list. Certain Specialty Drugs require Prior Authorization from the Plan, or benefits will be reduced or denied. Call Our consumer advisors at the number on the back of Your Member ID card or check Our website, bcbst.com, to find out which Specialty Drugs require Prior Authorization.

- 1. Covered Services
 - a. Provider-administered Specialty Drugs, including administration by a qualified Provider. Only those drugs listed as Provider-administered Specialty Drugs are Covered under this benefit.
- 2. Exclusions
 - a. Self-administered Specialty Drugs as identified on the Plan's formulary.
 - 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.

V. Reconstructive Surgery

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

- 1. Covered Services
 - a. Surgery to correct significant defects from congenital causes, (except where specifically excluded), accidents or disfigurement from a disease state.
 - b. Reconstructive breast Surgery as a result of a mastectomy or partial mastectomy (other than lumpectomy) including Surgery on the non-diseased breast needed to establish symmetry between the two breasts.
- 2. Exclusions
 - a. Services, supplies or prosthetics primarily to improve appearance.
 - b. Surgeries to correct or repair the results of a prior Surgical Procedure, the primary purpose of which was to improve appearance, and surgeries to improve appearance following a prior Surgical Procedure, even if that prior procedure was a Covered Service.

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

W. Skilled Nursing/Rehabilitative Facility Services

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

1. Covered Services

- a. Room and board in a semi-private room, general nursing care, medications, diagnostics and special care units.
- b. The attending Practitioner's services for professional care.
- c. Coverage is limited as indicated in the Attachment C: Schedule of Benefits.

2. Exclusions

- a. Custodial, domiciliary or private duty nursing services.
- b. Skilled Nursing services not received in a Medicare certified skilled nursing facility.

X. Supplies

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

1. Covered Services

- a. Supplies for the treatment of disease or injury used in a Practitioner's office, outpatient facility or inpatient facility.
- b. Supplies for treatment of disease or injury that are prescribed by a Practitioner and cannot be obtained without a Practitioner's prescription.

2. Exclusions

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

Y. Therapeutic/Rehabilitative/Habilitative Services

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

1. Covered Services

- a. Outpatient, home health or office therapeutic, rehabilitative and habilitative services. The services must be performed by, or under the direct supervision of a licensed therapist, upon written authorization of the treating Practitioner.

- b. Therapeutic/Rehabilitative/Habilitative Services include: (1) physical therapy; (2) speech therapy for restoration of speech; (3) occupational therapy; (4) manipulative therapy; and (5) cardiac and pulmonary rehabilitative services.
 - c. Coverage is limited, as indicated in Attachment C: Schedule of Benefits.
 - I. The limit on the number of visits for therapy applies to all visits for that therapy, whether received in a Practitioner's office, outpatient facility or home health setting.
 - II. Services received during an inpatient hospital, skilled nursing or rehabilitative facility stay are Covered as shown in the inpatient hospital, skilled nursing and rehabilitative facility section, and are not subject to the therapy visit limits.
2. Exclusions
- a. Enhancement therapy that is designed to improve Your physical status beyond Your pre-injury or pre-illness state.
 - b. Complementary and alternative therapeutic services, including, but not limited to: (1) massage therapy; (2) acupuncture; (3) craniosacral therapy; (4) vision exercise therapy; and (5) neuromuscular reeducation. Neuromuscular reeducation refers to any form of athletic training, rehabilitation program or bodily movement that requires muscles and nerves to learn or relearn a certain behavior or specific sequence of movements. Neuromuscular reeducation is sometimes performed as part of a physical therapy visit.
 - c. Modalities that do not require the attendance or supervision of a licensed therapist. These include, but are not limited to: (1) activities that are primarily social or recreational in nature; (2) simple exercise programs; (3) hot and cold packs applied in the absence of associated therapy modalities; (4) repetitive exercises or tasks that You can perform without a therapist, in a home setting; (5) routine dressing changes; and (6) custodial services that can ordinarily be taught to You or a caregiver.
 - d. Behavioral therapy, play therapy, communication therapy, and therapy for self correcting language dysfunctions as part of speech therapy, physical therapy or occupational therapy programs. Behavioral therapy and play therapy for behavioral health diagnoses may be Covered under the Behavioral Health benefit.
 - e. Duplicate therapy. For example, when You receive both occupational and speech therapy, the therapies should provide different treatments and not duplicate the same treatment.

Z. Vision – Medically Necessary for all Members

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

- 1. Covered Services
 - a. Services and supplies for the diagnosis and treatment of diseases and injuries to the eye.
 - b. The first set of eyeglasses or contact lenses required to adjust for vision changes due to cataract Surgery and obtained within 6 months following the Surgery.

2. Exclusions

- a. Routine vision services, including services, surgeries and supplies to detect or correct refractive errors of the eyes.
- b. Eyeglasses, contact lenses and examinations for the fitting of eyeglasses and contact lenses.
- c. Eye exercises and/or therapy.
- d. Visual training.

AA. Vision – Pediatric Vision

This Pediatric Vision section provides a wide range of benefits to Cover services associated with vision care for dependents under age 19. Plan benefits are based on the services and supplies described and provided in accordance with the benefit schedules set forth in Attachment C: Schedule of Benefits.

Medically Necessary and Appropriate routine vision care services.

1. Covered Services

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

2. Limitations

- a. Vision Examinations are covered once every Annual Benefit Period.
- b. Eyeglass frames are covered once every Annual Benefit Period.
- c. Eyeglass lenses or contact lenses are covered once every Annual Benefit Period.
- d. Prescription Sunglasses will be handled as any other lens.
- e. Benefits are not available more frequently than as specified in Attachment C: Schedule of Benefits.
- f. Discounts do not apply for benefits provided by other group benefit plans or promotional offers.

3. Exclusions:

- a. Medical and/or surgical treatment of the eye, eyes, or supporting structure, including surgeries to detect or correct refractive errors of the eyes.
- b. Eye exercises and/or therapy.
- c. Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses.
- d. Medical and/or surgical treatment of the eye, eyes or supporting structures.
- e. Charges for lenses and frames ordered while insured but not delivered within 60 days after Coverage is terminated, or vision testing examinations that occur after the date of termination.
- f. Charges for non-prescription sunglasses, photosensitive, anti-reflective or other optional charges when the charge exceeds the amount allowable for regular lenses.

- g. Charges filed for procedures determined by the Plan to be special or unusual, (i.e. orthoptics, vision training, subnormal vision aids, aniseikonic lenses, tonography, corneal refractive therapy, etc.)
- h. Charges for lenses that do not meet the Z80.1 or Z80.2 standards of the American National Standards Institute.
- i. Charges in excess of the Covered benefit as established by the Plan.
- j. Oversized Lenses.
- k. Corrected eyewear required by an employer as a condition of employment, and safety eyewear unless specifically Covered under the plan.
- l. Non-prescription lenses and frames, and non-prescription sunglasses.
- m. Services or materials provided by any other group benefit providing vision care.
- n. Two pairs of glasses in lieu of bifocals.
- o. Charges for replacement of broken, lost, or stolen lenses, contact lenses, or frames.
- p. Charges for services or materials from an Ophthalmologist, Optometrist or Optician acting outside the scope of his or her license.
- q. Charges for any additional service required outside basic vision analyses for contact lenses, except fitting fees.

EVIDENCE OF COVERAGE

Attachment B: Other Exclusions

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

1. Services or supplies not listed as Covered Services under Attachment A, Covered Service;
2. Services or supplies that are determined to be not Medically Necessary and Appropriate;
3. Services or supplies that are Investigational in nature including, but not limited to: (1) drugs; (2) biologicals; (3) medications; (4) devices; and (5) treatments;
4. Services or supplies provided by a Provider that is not accredited or licensed or are outside the scope of his/her/its license.
5. Illness or injury resulting from war, that occurred before Your Coverage began under this EOC and that is Covered by: (1) veteran's benefit; or (2) other coverage for which You are legally entitled;
6. Self treatment or training;
7. Staff consultations required by hospital or other facility rules;
8. Services that are free;
9. Services or supplies for the treatment of work related illness or injury, regardless of the presence or absence of workers' compensation coverage. This exclusion does not apply to injuries or illnesses of an Employee who is (1) a sole-proprietor of the Group, unless required by law to carry worker's compensation insurance; (2) a partner of the Group, unless required by law to carry worker's compensation insurance; or (3) a corporate officer of the Group, provided the officer filed an election not to accept Workers' Compensation with the appropriate government department;
10. Personal, physical fitness, recreational or convenience items and services, even if ordered by a licensed practitioner, including but not limited to: weight loss programs and equipment; physical fitness/exercise programs and equipment; devices and computers to assist in communication or speech (e.g., Dynabox); air conditioners, humidifiers, air filters and heaters; saunas, swimming pools and whirlpools; water purifiers; tanning beds; televisions; barber and beauty services;
11. Services or supplies received before Your effective date for Coverage with this Plan;
12. Services or supplies related to a Hospital Confinement, received before Your Effective Date for Coverage with this Plan;
13. Services or supplies received after Your Coverage under this Plan ceases for any reason. This is true even though the expenses relate to a condition that began while You were Covered. The only exception to this is described under the Extended Benefits section.
14. Services or supplies received in a dental or medical department maintained by or on behalf of the employer, mutual benefit association, labor union or similar group;

15. Services or charges to complete a claim form or to provide medical records or other administrative functions. We will not charge You or Your legal representative for statutorily required copying charges;
16. Charges for failure to keep a scheduled appointment;
17. Charges for telephone consultations, e-mail or web based consultations, except as may be provided for by specially arranged Care Management programs or emerging health care programs as described in the Prior Authorization, Care Management, Medical Policy and Patient Safety section of this EOC;
18. Court ordered examinations and treatment, unless Medically Necessary;
19. Room, board and general nursing care rendered on the date of discharge, unless admission and discharge occur on the same day;
20. Charges in excess of the Maximum Allowable Charge for Covered Services;
21. Any service stated in the Attachment A as a non-Covered Service or limitation;
22. Charges for services performed by You or Your spouse, or Your or Your spouse's parent, sister, brother or child;
23. Any charges for handling fees;
24. Safety items, or items to affect performance primarily in sports-related activities;
25. 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;
26. Services or supplies related to treatment of complications (except Complications of Pregnancy) that are a direct or closely related result of a Member's refusal to accept treatment, medicines, or a course of treatment that a Provider has recommended or has been determined to be Medically Necessary, including leaving an inpatient medical facility against the advice of the treating physician;
27. Services considered cosmetic, except when medically appropriate per medical policy. This exclusion also applies to surgeries to improve appearance following a prior Surgical Procedure, even if that prior procedure was a Covered Service. Services that could be considered cosmetic include, but are not limited to: (1) keloid removal; (2) dermabrasion; (3) chemical peels; (4) breast augmentation; (5) lipectomy; (6) laser resurfacing, (7) sclerotherapy injections, laser or other treatment for spider veins and varicose veins, (8) rhinoplasty, (9) panniculectomy/abdominoplasty, (10) Botulinum toxin;
28. Services that are always considered cosmetic, including but not limited to: (1) removal of tattoos; (2) facelifts; (3) body contouring or body modeling; (9) injections to smooth wrinkles; (4) piercing ears or other body parts, (5) rhytidectomy or rhytidoplasty (Surgery for the removal or elimination of wrinkles), (6) thigh plasty, (7) brachioplasty;
29. Blepharoplasty and browplasty;
30. Charges relating to surrogate pregnancy, including but not limited to maternity and delivery charges, whether or not the surrogate mother is Covered under this plan;
31. Sperm preservation;

32. Services or supplies for orthognathic Surgery, a discipline to specifically treat malocclusion except as appropriate per medical policy and when performed in conjunction with orthodontia for members under age 19. Orthognathic surgery is not surgery to treat cleft palate or TMJ/TMD.
33. Services or supplies for Maintenance Care;
34. Private duty nursing;
35. Services or supplies to treat sexual dysfunction, regardless of cause, including but not limited to erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido;
36. Charges for injuries due to chewing or biting or received in the course of other dental procedures;
37. Services or supplies related to complications of cosmetic procedures, complications of bariatric Surgery; re-operation of bariatric Surgery or body remodeling after weight loss;
38. Cranial orthosis, including helmet or headband, for the treatment of non-synostotic plagiocephaly;
39. Chelation therapy, except for (1) control of ventricular arrhythmias or heart block associated with digitalis toxicity; (2) Emergency treatment of hypercalcemia; (3) extreme conditions of metal toxicity, including thalassemia with hemosiderosis; (4) Wilson's disease (hepatolenticular degeneration); and (5) lead poisoning;
40. Vagus nerve stimulation for the treatment of depression;
41. Balloon sinuplasty for treatment of chronic sinusitis;
42. Treatment for benign gynecomastia;
43. Treatment for hyperhidrosis;
44. Intradiscal annuloplasty to treat discogenic back pain. This procedure provides controlled delivery of heat to the intervertebral disc through an electrode or coil.

EVIDENCE OF COVERAGE

Attachment D: Eligibility

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

A. **Subscriber**

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

1. Be a full-time Employee of the Group, who is Actively At Work; and
2. Satisfy all eligibility requirements of the Employer and Group Agreement; and
3. Enroll for Coverage from the Plan by submitting a completed and signed Enrollment Form or other required documentation to Your Group representative; and
4. Satisfy any new Employee or rehire eligibility period required by the Employer.

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

B. **Covered Dependents**

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

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

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

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

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

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

C. Loss of Eligibility

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

D. Rehire Provision

If your Coverage is reinstated within 6 months of the last day of employment, You will be considered as having continuous Coverage under this EOC for the purpose of administering the Deductible and Out-of-Pocket Maximum specified in the Schedule of Benefits. However, expenses incurred while Coverage was not in effect, will not be considered eligible expenses.



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