

Evidence of Coverage

Health Benefit Plan



City of Murfreesboro – PPO and
HRA Plans, Network P

City of Murfreesboro
Group Number 125224
January 1, 2015

NOTICE

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

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

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INTRODUCTION

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

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

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

While the Employer has delegated discretionary authority to make any benefit or eligibility determinations to the administrator, the Employer also has the authority to make any final Plan determination. The Employer, as the Plan Administrator, and BlueCross also have the authority to construe the terms of Your Coverage. The Plan and BlueCross shall be deemed to have properly exercised that authority unless it abuses its discretion when making such determinations, whether or not the Employer's benefit plan is subject to ERISA.

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

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

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

BENEFIT ADMINISTRATION ERROR

If the administrator makes an error in administering the benefits under this EOC, the Plan may provide additional benefits or recover any overpayments from any person, insurance company, or plan. No such error may be used to demand more benefits than those otherwise due under this EOC.

WHAT IS A HIGH DEDUCTIBLE HEALTH PLAN?

A High Deductible Health Plan (HDHP) has a higher Calendar Year Deductible than a typical health plan. Most services are Covered only after You meet Your Deductible. Some preventive care benefits may be paid before the Deductible is satisfied. See Attachment C: Schedule of Benefits.

NOTIFICATION OF CHANGE IN STATUS

Changes in Your status can affect the service under the Plan. To make sure the Plan works correctly, please notify the Employer when You change:

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

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

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

ELIGIBILITY FOR COVERAGE

Eligibility for Individual Coverage

Each Employee will become eligible for coverage under this Plan with respect to himself or herself on the first day of the month following or coinciding with the date of completion of a Service Waiting Period of 60 days of service for the Plan Sponsor. If the Employee is unable to begin work as scheduled, then his or her coverage will become effective on such later date when the Employee begins work. Each Employee who was covered under the Prior Plan, if any, will be eligible on the Effective Date of this Plan. Any Service Waiting Period or portion thereof satisfied under the Prior Plan, if any, will be applied toward satisfaction of the Service Waiting Period of this Plan.

An Employee who is receiving a long term disability benefit and who was employed with the Plan Sponsor a minimum of 90 days prior to becoming disabled and was covered by the Plan at the time the Employee became disabled is eligible for coverage. Coverage will terminate at age 65 for an individual who did not complete 15 years of continuous service for the Plan Sponsor and who was not continuously covered under the Plan Sponsor's health plan for five years.

Eligibility for Retiree and LTD Enrollee Coverage

A person is eligible for Retiree or LTD Enrollee coverage from the first day that he or she:

1. Is a Retiree or LTD Enrollee of the Employer;
2. Has attained age 55 (but not yet reached age 65), completed 15 years of continuous service with the Plan Sponsor and had five years continuous coverage in the Plan Sponsor's health plan; or
3. Has completed 30 years of continuous service with the Plan Sponsor and had coverage under the Plan Sponsor's health plan for five years prior to retirement.
4. Has terminated employment with the intent to apply or pending LTD approval.

A Retiree or LTD Enrollee who is Medicare eligible must be enrolled in Medicare Parts A and B to be eligible under the Plan.

Coverage under the Plan will terminate for a Retiree who did not complete 15 years of continuous service for the Plan Sponsor and who was not continuously covered under the Plan Sponsor's health plan for five years.

A Retiree must enroll for coverage by filling out and signing an enrollment application. The enrollment will be "timely" if the completed form and the first month's premium is received by the Plan Sponsor no later than 31 days after the person becomes eligible for coverage (termination date as an Active Employee).

Eligibility for Dependent Coverage

Each Employee, Retiree or LTD Enrollee will become eligible for coverage under this Plan for his or her Dependents as follows:

1. On his or her date of eligibility for coverage for himself or herself under the Plan;

2. On the date coverage for his or her Dependents first becomes available under any amendment to the Plan, if such coverage was not provided under the Plan on the Effective Date of the Plan; and
3. On the first date upon which he or she acquires a Dependent.

A Dependent Spouse acquired by marriage after the date of the Employee's retirement or LTD enrollment may only be enrolled in family coverage under the same Plan as the Retiree or LTD Enrollee.

A Dependent Child will cease to be eligible under the Plan when a Retiree or LTD Enrollee enrolls in Medicare Parts A and B, unless the Dependent Child is also enrolled in Medicare Parts A and B or if the Dependent Child is eligible under another parent's plan or the pre-Medicare group.

In no event will any Dependent Child or spouse be covered as a Dependent of more than one Employee, Retiree or LTD Enrollee who is covered under the Plan.

Any reference in this Plan to an Employee, Retiree or LTD Enrollee's Dependent being covered means that such Employee, Retiree or LTD Enrollee is covered for Dependent Coverage.

Eligibility for Survivor Coverage

A person is eligible for coverage if he or she is the surviving spouse (who has not remarried) or Dependent Child of an Employee who had worked a minimum of 15 years for the Plan Sponsor and the surviving spouse or Dependent Child was covered under the Plan at the time of the Employee's death.

Coverage for the surviving spouse and Dependent Child may continue until the surviving spouse remarries, or goes to work full-time, whichever occurs first. Upon Medicare eligibility, a surviving spouse and/or dependent must be enrolled in Medicare Parts A and B to continue eligibility under the Plan.

A Dependent Child cannot be enrolled in an individual contract under the plan unless he or she has elected COBRA coverage.

ENROLLMENT IN THE PLAN

Eligible Employees, Retirees or LTD Enrollees 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.

Initial Enrollment Period

Eligible Employees, Retirees or LTD Enrollees 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 (furnished by the Plan Sponsor) to the administrator during that initial enrollment period.

Open Enrollment Period

Eligible Employees, Retirees or LTD Enrollees shall be entitled to apply for Coverage for themselves and eligible dependents during their Employer's Open Enrollment Period. The eligible Employee must: (1) include all requested information; (2) sign; and (3) submit an Enrollment Form (furnished by the Plan Sponsor) to the administrator 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. Coverage for Participants enrolling during an Open Enrollment Period will become effective on January 1, unless the Employee has not satisfied the Service Waiting Period, in which event coverage for the Employee and his or her Dependents will become effective on the day following completion of the Service Waiting Period.

Coverage for New Dependents

Coverage for a Dependent acquired by reason of marriage, birth, legal adoption, placement for adoption, or court or administrative order shall take effect on the date of the event giving rise to dependent status. Coverage is effective only if the Plan Sponsor receives required documentation and is notified of the event within 31 days of its occurrence.

- a. Requirement for Employee, Retiree or LTD Enrollee Coverage. No coverage for Dependents of an Employee, Retiree or LTD Enrollee will become effective unless the Employee, Retiree or LTD Enrollee is, or simultaneously becomes, eligible for coverage for himself or herself under the Plan.
- b. Coverage as Both Employee, Retiree or LTD Enrollee and Dependent. No person may be simultaneously covered under this Plan as both an Employee, Retiree or LTD Enrollee and a Dependent.
- c. Medicaid Coverage. An individual's eligibility for any State Medicaid benefits will not be taken into account by the Plan in determining that individual's eligibility under the Plan.
- d. FMLA Leave. Regardless of any requirements set forth in the Plan, the Plan shall at all times comply with FMLA.
- e. Legally Adopted (or Placed) Child. If the legally adopted (or placed) child has Coverage of his or her medical expenses from a public or private agency or entity, the Subscriber may not add the child until that coverage ends. Any other new 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 administrator within 31 days of the date that person first becomes eligible for Coverage.

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Special Enrollment for Employees or LTD Enrollees

The Plan provides special enrollment periods that allow Employees or LTD Enrollees to enroll in the Plan, even if they declined enrollment during an initial or subsequent eligibility period.

Currently participating Retirees are eligible for special enrollment rights under “**New Dependent of Employee, LTD Enrollee, or Retiree**” only.

Loss of Other Coverage

If an Employee or LTD Enrollee declined enrollment for himself or herself or his or her Dependents (including his or her spouse) because of other health coverage, he or she may enroll for coverage for himself or herself and/or his or her Dependents if the other health coverage is lost. The Employee or LTD Enrollee must make written application for special enrollment within 31 days of the date the other health coverage was lost. For example, if the Employee or LTD Enrollee loses his or her other health coverage on July 1, he or she must notify the Plan Sponsor and apply for coverage by close of business on July 31.

The following conditions apply to any eligible Employee or LTD Enrollee and Dependents:

An Employee or LTD Enrollee may enroll during this special enrollment period:

1. If the Employee or LTD Enrollee is eligible for coverage under the terms of this Plan;
2. The Employee or LTD Enrollee is not currently enrolled under the Plan;
3. When enrollment was previously offered, the Employee or LTD Enrollee declined because of coverage under another group health plan or health insurance coverage; and
4. If the other coverage was terminated due to loss of eligibility for the coverage (including due to legal separation, divorce, death, termination of employment, or reduction in the number of hours), or because employer contributions for the coverage were terminated.

An Employee or LTD Enrollee who is already enrolled in a benefit package may enroll in another benefit package under the Plan if a Dependent of that Employee or LTD Enrollee has a special enrollment right in the Plan because the Dependent lost eligibility for other coverage. The Employee or LTD Enrollee must make written application for special enrollment in the new benefit package within 31 days of the date the other health coverage was lost.

The Employee or LTD Enrollee is not eligible for this special enrollment right if:

1. The other coverage was COBRA continuation coverage and the Employee or LTD Enrollee did not exhaust the maximum time available to him or her for that COBRA coverage; or
2. The other coverage was lost due to non-payment of requisite contribution / premium or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other plan).

If the conditions for special enrollment are satisfied, coverage for the Employee or LTD Enrollee and/or his or her Dependent(s) will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written request is received by the Plan.

New Dependent of Employee, LTD Enrollee, or Retiree

If an Employee, LTD Enrollee or currently participating Retiree acquires a new Dependent as a result of marriage, birth, adoption, or placement for adoption, he or she may be able to enroll himself or herself and his or her Dependents during a special enrollment period. The Employee, LTD Enrollee or currently participating Retiree must make written application for special enrollment within 31 days of the date he or she acquires the new Dependent. For example, if the Employee is married on July 1, he or she must notify the Plan Sponsor and apply for coverage by close of business on July 31.

The following conditions apply to any eligible Employee or LTD Enrollee and Dependents:

An Employee or LTD Enrollee may enroll himself or herself and/or his or her eligible Dependents during this special enrollment period if:

1. The Employee or LTD Enrollee is eligible for coverage under the terms of this Plan; and
2. The Employee or LTD Enrollee has acquired a new Dependent through marriage, birth, adoption, or placement for adoption.

If the conditions for special enrollment are satisfied, coverage for the Employee or LTD Enrollee and his or her Dependent(s) will be effective at 12:01 A.M.:

1. For a marriage, on the date of the marriage;
2. For a birth, on the date of birth; or
3. For an adoption or placement for adoption, on the date of the adoption or placement for adoption.

Additional Special Enrollment Rights

Employee or LTD Enrollees and Dependents who are eligible but not enrolled are entitled to enroll under the following circumstances:

1. The Employee or LTD Enrollee's or Dependent's Medicaid or State Child Health Insurance Plan (i.e. CHIP) coverage has terminated as a result of loss of eligibility and the Employee or LTD Enrollee requests coverage under the Plan within 60 days after the termination; or
2. The Employee or LTD Enrollee or Dependent become eligible for a contribution / premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and the Employee or LTD Enrollee requests coverage under the Plan within 60 days after eligibility is determined.

Effective Date of Coverage; Conditions

All conditions for effectiveness of coverage under the Plan, which are set forth in the section entitled "Enrollment in the Plan," will apply to Participants enrolling during a Special Enrollment Period. Coverage for Participants enrolling during a Special Enrollment Period will become effective on the date of the qualified event giving rise to the Special Enrollment.

National Medical Support Notice

"National Medical Support Notice" or "NMSN" shall mean a notice that contains the following information:

1. Name of an issuing State agency;

2. Name and mailing address (if any) of an Employee, Retiree or LTD Enrollee who is a Participant under the Plan;
3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Participant or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying child support order.

Upon receiving a National Medical Support Notice, the Plan Sponsor shall:

1. Notify the State agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:
 - a. Whether the child is covered under the Plan; and
 - b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to effectuate the coverage; and
2. Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the Plan Sponsor shall:

1. Establish reasonable, written procedures for determining the qualified status of a National Medical Support Notice; and
2. Permit any Participant to designate a representative for receipt of copies of the notices that are sent to the Participant with respect to the Notice.

“GINA”

“GINA” prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term “genetic information” means, with respect to any individual, information about:

1. Such individual’s genetic tests;
2. The genetic tests of family members of such individual; and
3. The manifestation of a disease or disorder in family members of such individual.

The term “genetic information” includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions, and applying preexisting conditions. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care Provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use

them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

Lay-off/Rehire Provision

If a Subscriber's Coverage is reinstated within 30 days of the last date of employment, the Subscriber will be considered as having continuous Coverage under this EOC. However, expenses incurred while Coverage was not in effect will not be considered eligible expenses.

TERMINATION OF COVERAGE

Termination Dates of Individual Coverage

The coverage of any Employee for himself or herself under this Plan will terminate on the earliest to occur of the following dates:

1. The last day of the month following termination of the Plan;
2. The last day of the month for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for himself or herself to which he or she has agreed in writing;
3. The last day of the month in which he or she ceases to be eligible for such coverage under the Plan;
4. The last day of the month in which the termination of employment occurs; or

The last day of the month in which an Employee or his or her Dependent submits, or has knowledge of the submission of, a claim involving fraud or misrepresentation or provides any information involving fraud or misrepresentation to the Plan, including enrollment information.

Termination Dates of Retiree Coverage for Retiree, Retiree's Spouse, LTD Enrollee and Dependents

The coverage of any Retiree, LTD Enrollee, his or her spouse and Dependents who are covered under the Plan will terminate on the earliest to occur of the following dates:

1. The date of termination of the Plan;
2. The date of death of the covered Retiree or LTD Enrollee;
3. The date of the expiration of the last period for which the Retiree or LTD Enrollee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for himself or herself to which he or she has agreed in writing;
4. The date the Retiree or LTD Enrollee ceases to be eligible for such coverage under the Plan; or
5. The date on which a Retiree or LTD Enrollee or his or her Dependents submits, or has knowledge of the submission of, a claim involving fraud or misrepresentation or provides any information involving fraud or misrepresentation to the Plan, including enrollment information.

Termination Dates of Dependent Coverage

The coverage for any Dependents of any Employee, Retiree or LTD Enrollee who are covered under the Plan will terminate on the earliest to occur of the following dates:

1. The date of termination of the Plan;
2. The last day of the month in which there is discontinuance of coverage for Dependents under the Plan;
3. For Dependents only: the last day of the month in which there is termination of the Employee, Retiree or LTD Enrollee's coverage for himself or herself under the Plan;
4. The date of the expiration of the last period for which the Employee, Retiree or LTD Enrollee has made a contribution, in the event of his or her failure to make, when

- due, any contribution for coverage for Dependents to which he or she has agreed in writing;
5. In the case of a Child age 26 or older for whom coverage is being continued due to mental or physical inability to earn his or her own living, the earliest to occur of:
 - a. Cessation of such inability;
 - b. Failure to furnish any required proof of the uninterrupted continuance of such inability or to submit to any required examination; or
 - c. Upon the Child's no longer being dependent on the Employee, Retiree or LTD Enrollee for his or her support;
 6. The last day of the month in which such person ceases to be a Dependent, as defined herein, except as may be provided for in other areas of this section; or
 7. Immediately after an Employee, Retiree or LTD Enrollee or his or her Dependent submits, or has knowledge of the submission of, a claim involving fraud or misrepresentation or provides any information involving fraud or misrepresentation to the Plan, including enrollment information.

Termination for Cause

The Plan may terminate Your Coverage for cause if:

1. You fail to make a required Member payment when it is due; or
2. You fail to cooperate with the Plan or Employer as required; or
3. You have made a material misrepresentation or committed fraud against the Plan. This provision includes, but is not limited to, furnishing incorrect or misleading information or permitting the improper use of the membership ID card.

Right to Request a Hearing

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

Payment For Services Rendered After Termination of Coverage

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

Extended Benefits

If You are hospitalized on the date the ASA is terminated, benefits for Hospital Services will be provided for: (1) 60 days; (2) until You are covered under another Plan; or (3) until You are 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

Federal Law

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

A. Eligibility

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

1. Subscribers. Loss of Coverage because of:
 - a. The termination of employment except for gross misconduct.
 - b. A reduction in the number of hours worked by the Subscriber.
2. Covered Dependents. Loss of Coverage because of:
 - a. The termination of the Subscriber’s Coverage as explained in subsection (a), above.
 - b. The death of the Subscriber.
 - c. Divorce or legal separation from the Subscriber.
 - d. The Subscriber becomes entitled to Medicare.
 - e. A Covered Dependent reaches the limiting age.

B. Enrolling for COBRA Continuation Coverage

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

1. The Subscriber’s termination of employment, reduction in hours worked, death or entitlement to Medicare coverage; or
2. The Subscriber or Covered Dependent notifies the Employer, in writing, within 60 days after any other qualifying event set out above.

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

C. Payment

You must submit any Payment required for COBRA Continuation Coverage to the administrator at the address indicated on Your Payment notice. If You do not enroll when first becoming eligible, the Payment due for the period between the date You first become eligible

and the date You enroll for COBRA Continuation Coverage must be paid to the Employer (or to the administrator, if so directed by the Employer) within 45 days after the date You enroll for COBRA Continuation Coverage. After enrolling for COBRA Continuation Coverage, all Payments are due and payable on a monthly basis as required by the Employer. If the Payment is not received by the administrator on or before the due date, Coverage will be terminated, for cause, effective as of the last day for which Payment was received as explained in the Termination of Coverage Section. The administrator may use a third party vendor to collect the COBRA Payment.

D. Coverage Provided

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

E. Duration of Eligibility for COBRA Continuation Coverage

COBRA Continuation Coverage is available for a maximum of:

1. 18 months if the loss of Coverage is caused by termination of employment or reduction in hours of employment; or
2. 29 months of Coverage. If, as a qualified beneficiary who has elected 18 months of COBRA Continuation Coverage, You are determined to be disabled within the first 60 days of COBRA Continuation Coverage, You can extend Your COBRA Continuation Coverage for an additional 11 months, up to 29 months. Also, the 29 months of COBRA Continuation Coverage is available to all non-disabled qualified beneficiaries in connection with the same qualifying event. "Disabled" means disabled as determined under Title II or XVI of the Social Security Act. In addition, the disabled qualified beneficiary or any other non-disabled qualified beneficiary affected by the termination of employment qualifying event must:
 - a. 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
 - b. 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
3. 36 months of Coverage if the loss of Coverage is caused by:
 - a. the death of the Subscriber;
 - b. loss of dependent child status under the Plan;
 - c. the Subscriber becomes entitled to Medicare; or
 - d. divorce or legal separation from the Subscriber; or
4. 36 months for other qualifying events. If a Covered Dependent is eligible for 18 months of COBRA Continuation Coverage as described above, and there is a second qualifying event (e.g., divorce), You may be eligible for 36 months of COBRA Continuation Coverage from the date of the first qualifying event.

F. Termination of COBRA Continuation Coverage

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

1. The Payment for such Coverage is not submitted when due; or
2. You become Covered as either a Subscriber or dependent by another group health care plan, and that coverage is as good as or better than the COBRA Continuation Coverage; or
3. The ASA is terminated; or
4. You become entitled to Medicare Coverage; or
5. The date that You, otherwise eligible for 29 months of COBRA Continuation Coverage, are determined to no longer be disabled for purposes of the COBRA law.

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

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

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.

H. Continued Coverage During a Military Leave of Absence

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

I. The Trade Adjustment Assistance Reform Act of 2002

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

PRIOR AUTHORIZATION, CARE MANAGEMENT, MEDICAL POLICY AND PATIENT SAFETY

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

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

A. Prior Authorization

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

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

- *Inpatient Hospital and Inpatient Hospice stays (except maternity admissions)*
- *Skilled nursing facility and rehabilitation facility admissions*
- *Certain Outpatient Surgeries and/or procedures*
- *Certain Provider Administered Specialty Drugs*
- *Prosthetics, Orthotics, and Durable Medical Equipment (DME) greater than \$500.00*
- *Advanced Radiological Imaging Services (MRIs, CT and PET Scans)*

- *Other services not listed at the time of printing may be added to the list of services that require Prior Authorization. Notice of changes to the Prior Authorization list will be made via Our Web site and the Member newsletter. You may also call Our customer service department at the phone number on Your ID card to find out which services require Prior Authorization.*

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

Network Providers in Tennessee will request Prior Authorization for You.

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

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

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

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

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

The Member is not held harmless if:

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

Out-of-network services involving radiologists, anesthesiologists, pathologists, labwork, emergency room physicians and ambulance services, occurring at a network facility or ordered by a Network Provider, shall be reimbursed based on Billed Charges and apply toward the Network Deductible, Coinsurance, and Out-of-Pocket Maximums.

B. Care Management

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

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

Wellness Portal - Your member wellness portal is an interactive website that encourages understanding personal health risks and making healthy lifestyle choices. Through Your member wellness portal, You have access to a personal health assessment and personal wellness report, self-directed health coaching programs with structured lesson plans, educational articles and video content, tracking tools and individual action plans. You may choose to participate in self-directed coaching programs to assist with weight management, blood pressure, nutrition, physical activity, stress management, smoking cessation, and much more.

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.

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) Emergency services management program; (2) transition of care program; (3) condition-specific care coordination program; and (4) disease management.

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 the catastrophic medical and transplant case management program. Registered nurses work with health care Providers, the Member, and primary caregivers to coordinate the most appropriate, cost-efficient care settings. Case managers maintain regular contact with Members throughout treatment, coordinate clinical and health plan Coverage issues, and help families utilize available community resources.

After evaluation of the Member's condition, it may be determined that alternative treatment is Medically Necessary and Appropriate.

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

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

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

C. Medical Policy

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

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

Medical policies state whether or not a technology is Medically Necessary, Investigational or cosmetic. As technologies change and improve, and as Members’ needs change, We may reevaluate and change medical policies without formal notice. You may check Our medical policies at www.bcbst.com. Enter “medical policy” in the Search field. BlueCross’ Medical Policies are made a part of this EOC by reference.

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

D. Patient Safety

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

INTER-PLAN PROGRAMS

A. Out-of-Area Services

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

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

1. BlueCard® PPO Program

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

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

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

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

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

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

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

REMEMBER: You are responsible for receiving Prior Authorization from Us. If Prior Authorization is not received, Your benefits may be reduced or denied. Call the

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

2. Negotiated (non-BlueCard® Program) National Account Arrangements

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

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

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

a. 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.

b. 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.

4. 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, either You or the Provider must submit a claim form to Us. We will review the claim, and let You or the Provider know if We need more information before We pay or deny the claim. We follow Our internal administration procedures when We adjudicate claims. If these procedures differ from those required by the ERISA claims regulations, the ERISA claims regulations shall control.

A. Claims

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

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

B. Claims Billing

1. You should not be billed or charged for Covered Services rendered by Network Providers, except for required Member Payments. The Network Provider will submit the claim directly to Us.
2. You may be charged or billed by an Out-of-Network Provider for Covered Services rendered by that Provider. If You use an Out-of-Network Provider, You are responsible for the difference between Billed Charges and the Maximum Allowable Charge for a Covered Service. You are also responsible for complying with any of the Plan's medical management policies or procedures (including obtaining Prior Authorization of such Services, when necessary).
 - a. If You are charged or receive a bill, You must submit a claim to Us.
 - b. To be reimbursed, You must submit the claim within 1 year and 90 days from the date a Covered Service was received. If You do not submit a claim within the 1 year and 90 day time period, it will not be paid. If it is not reasonably possible to submit the claim within the 1 year and 90 day time period, the claim will not be invalidated or reduced.
3. Not all Covered Services are available from Network Providers. There may be some Provider types that We do not contract with. These Providers are called Non-Contracted Providers. Claims for services received from Non-Contracted Providers are handled as described in sections 2. a. and b. above. You are also responsible for complying with any of the Plan's medical management policies or procedures (including, obtaining Prior Authorization of such Services, when necessary).

4. You may request a claim form from Our customer service department. We will send You a claim form within 15 days. You must submit proof of payment acceptable to Us with the claim form. We may also request additional information or documentation if it is reasonably necessary to make a Coverage decision concerning a claim.
5. A Network Provider or an Out-of-Network Provider may refuse to render a service, or reduce or terminate a service that has been rendered, or require You to pay for what You believe should be a Covered Service. If this occurs:
 - a. You may submit a claim to Us to obtain a Coverage decision concerning whether the Plan will Cover that service. For example, if a provider requires You to pay for a service when rendered, You may submit a claim to the Plan to obtain a Coverage decision about whether it is Covered by the Plan.
 - b. You may request a claim form from Our customer service department. We will send You a claim form within 15 days. We may request additional information or documentation if it is reasonably necessary to make a Coverage decision concerning a claim.
6. Providers may bill or charge for Covered Services differently. Network Providers are reimbursed based on Our agreement with them. Different Network Providers have different reimbursement rates for different services. Your Out-of-Pocket expenses can be different from Provider to Provider.

C. Payment

1. If You received Covered Services from a Network Provider, the Plan will pay the Network Provider directly. These payments are made according to Our agreement with that Network Provider. You authorize assignment of benefits to that Network Provider. Covered Services will be paid at the Network Benefit level.
2. If You received Covered Services from an Out-of-Network Provider, You must submit, in a timely manner, a completed claim form for Covered Services. If the claim does not require further investigation, the Plan will reimburse You. The Plan may make payment for Covered Services either to the Provider or to You, at its discretion. The Plan's payment fully discharges its 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 are responsible for the difference in the Billed Charge and the Maximum Allowable Charge for that Covered Service. The Plan's payment fully discharges its obligation related to that claim.
4. If the ASA is terminated, all claims for Covered Services rendered prior to the termination date, must be submitted to the Plan within 1 year and 90 days from the date the Covered Services were received.
5. We will pay benefits according to the Plan 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. Neither the Plan nor We are responsible for over or under payment of claims if Our information is not complete or is inaccurate. We will make reasonable efforts to obtain and verify relevant facts when claim forms are submitted.
6. When a claim is paid or denied, in whole or part, We will produce an Explanation of Benefits (EOB). This will describe how much was paid to the Provider, and also let

You know if You owe an additional amount to that Provider. The administrator will make the EOB available to You at www.bcbst.com, or by calling the customer service department at the number listed on Your membership ID card.

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

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

D. Complete Information

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

Mail all claim forms to:

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

COORDINATION OF BENEFITS

A. Purpose of Coordination of Benefits

If another Payor provides coverage to You, the Plan may coordinate its benefits with those of that other Payor (the “Primary Plan”). The Plan will follow the “Maintenance of Benefits” alternative set forth in chapter 0780-1-53 of the Tennessee Regulations (the “State COB Regulations”) to coordinate benefits when it is the secondary Plan .

When the Plan is secondary (meaning it determines its benefits after another Plan), its benefits plus those of the Primary Plan will be less than 100% of Allowable Expenses unless the Primary Plan, by itself, provides benefits at 100% of Allowable Expenses. When services are provided by a Network Provider, you will not be required to pay more than \$2,000 for any Covered person in any Calendar Year toward the expenses or services Covered under this Plan for which the Plan is the Secondary Plan pursuant to this provision.

B. Information About Coverage From Other Payors

Information about Your Coverage by other Payors, which is set forth on the enrollment form, is material information. A Subscriber must submit a completed change form if there is any change in the Subscriber’s Coverage or a Covered Dependent’s Coverage by other Payors during the term of Coverage by the Plan. You must cooperate, upon reasonable request, to permit the Plan to coordinate its Coverage with that provided by other Payors.

C. Group Coordination of Benefits

The Plan shall coordinate benefits as follows:

1. Applicability
 - a. This coordination of benefits (COB) provision applies when You have health care coverage under more than one plan.
 - b. If this COB provision applies, the order of benefit determination rules are applied. Those rules determine whether the Plan’s benefits are determined before or after those of another plan. The Plan’s benefits:
 - (1) Shall not be reduced when, under the order of benefit determination rules, the Plan determines its benefits before another plan (i.e. is the Primary Plan); but
 - (2) May be reduced when, under the order of benefits determination rules, another plan determines its benefits first. This reduction is described in subdivision d below, “Effect on the Benefits of This Plan.”
2. Definition of Terms Used in this Section
 - a. A “Plan” provides benefits or services for medical or dental care or treatment, from:
 - (1) Group insurance or group-type coverage, whether insured or uninsured. This includes health maintenance, prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
 - (2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state Medicaid Plan (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act).

- b. Primary Plan and Secondary Plan. The order of benefit determination rules state whether this Plan is a Primary Plan or secondary Plan as to another Plan covering the person. When this Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits. 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. When there are more than 2 Plans covering the person, this Plan may be a Primary Plan as to 1 or more other Plans and may be a secondary Plan as to a different Plan(s).
- c. Allowable Expense means a necessary, reasonable and customary item of expense for health care, when that expense is Covered at least in part by one or more Plans covering the person for whom the claim is made. 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. When benefits are reduced under a Primary Plan because a Covered person does not comply with the Plan provisions, the amount of that reduction will not be considered an Allowable Expense.
- d. Claim Determination Period means a Calendar Year. However, it does not include any part of a year during which a person has no Coverage under this Plan.

3. Order of Benefit Determination Rules

- a. General. When there is a basis for a claim under this Plan and another Plan, this Plan is a secondary Plan, which determines its benefits after those of the other Plan, unless:
 - (1) The other Plan has rules coordinating its benefits with those of this Plan; and
 - (2) Both those rules and this Plan's rules, set forth below, require that this Plan's benefits be determined before those of the other Plan.
- b. Rules. This Plan determines its order of benefits using the first of the following rules that applies:
 - (1) Nondependent/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;
 - (2) Dependent child/parents not separated or divorced. Except as stated in paragraph 3(b) 3, when this Plan and another Plan cover the same child as a dependent of different parents:
 - i. 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
 - ii. If both parents have the same birthday, the benefits of the Plan that covered one parent longer are determined before those of the Plans that Covered the other parent for a shorter period of time. However, if the other Plan does not have the rule described previously in 3(b)(2)(a) or (b) and if, as a result, the

Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

- (3) Dependent child/separated or divorced. 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:
 - i. First, the Plan of the parent with custody of the child;
 - ii. Then, the Plan of the spouse of the parent with the custody of the child; and
 - iii. Finally, the Plan of the parent not having custody of the child. However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the Plan that is obligated to pay or provide benefits to that child under that decree has actual knowledge of those terms, the benefits of that Plan are determined first.
- (4) Joint custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in paragraph 3(b)(2).
- (5) Active/inactive Employee. The benefits of a Plan that covers a person as an Employee, who is neither laid off nor retired, are determined before those of a Plan that covers that person as a laid off or retired Employee. The same would be true if a person is a dependent of a person Covered as a retiree and an Employee. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule (5) is ignored.
- (6) Longer/shorter length of Coverage. If none of the previous rules determines the order of benefits, the benefits of the Plan that Covered an Employee, Member or Subscriber for the longer period are determined before those of the Plan covering that person for the shorter period.

D. Effect On the Benefits Of This Plan

1. When This Section Applies. This section applies when, in accordance with the Order of Benefit Determination Rules, this Plan is a secondary Plan as to one or more other Plans (the "Other Plans"). In that event, the benefits of this Plan may be reduced under this section.
2. Reduction in this Plan's benefits.
 - a. The benefits that would be payable for the allowable expenses under this Plan in the absence of this COB provision will be reduced by the benefits payable under the other Plans for the expenses Covered in whole or in part under this Plan. This applies whether or not claim is made under a Plan.
 - b. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both the expense incurred and the benefit payable.

- c. When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

E. Right To Receive And Release Needed Information

Certain facts are needed to apply these COB rules. The Plan has the right to decide which facts it needs. It may get needed facts from or give information to any other organization or person. The Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give the Plan any facts it needs to pay the claim.

F. Facility of Payment

A payment made under Other Plans may include an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the Other Plan that made that payment. That amount will then be treated as though it were a benefit paid under this Plan, which 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.

G. Right of Recovery

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

1. The person it has paid or for whom it has made such payment;
2. Other plans; or
3. Other organizations.

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

H. Subscribers and Covered Dependents Enrolled for Medicare

The Plan will follow applicable Medicare statutes and regulations to determine if it or Medicare should be the Primary Plan for Covered Services rendered to You when You are also eligible for Medicare Coverage. The Plan will provide You with a summary of those statutes and regulations upon request.

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

1. This Procedure is the exclusive method of resolving any Dispute. Exemplary or punitive damages are not available in any Grievance or litigation, pursuant to the terms of this EOC. Any decision to award damages must be based upon the terms of this EOC.
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. This Procedure incorporates the definitions of: (1) Adverse Benefit Determination; (2) urgent care; and (3) pre-service and post-service claims (“Claims”), that are in the Employee Retirement Income Security Act of 1974 (“ERISA”); Rules and Regulations for Administration and Enforcement; Claims Procedure (the “Claims Regulation”).

Adverse Benefit Determination means:

- a. A determination by a health carrier or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health carrier's health benefit plan does not meet the health carrier's requirements for medical necessity, appropriateness, healthcare setting, level of care or effectiveness and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit;
 - b. The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier of a covered person's eligibility to participate in the health carrier's health benefit plan; or
 - c. Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment for, in whole or in part, a benefit.
5. You may request a form from the Plan to authorize another person to act on Your behalf concerning a Dispute.
 6. We, the Plan and You may agree to skip one or more of the steps of this Procedure if it will not help to resolve the Dispute.

7. Any Dispute will be resolved in accordance with applicable Tennessee or Federal laws and regulations, the ASA 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 the customer service department if You have any questions about how to file a Claim or to attempt to resolve any Dispute. Making an Inquiry does not stop the time period for filing a Claim or beginning a Dispute. You do not have to make an Inquiry before filing a Grievance.

2. First Level Grievance

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

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

a. Grievance Process

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

b. Written Decision

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

- (1) For a pre-service claim, within 30 days of receipt of Your request for review;
- (2) For a post-service claim, within 60 days of receipt of Your request for review; and
- (3) 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:

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

- (2) The basis of the committee's decision; and
- (3) Reference to the documentation or information upon which the committee based its decision. You may receive a copy of such documentation or information, without charge, upon written request.

2. Second Level Grievance

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

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

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

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

a. Grievance Process

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

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

- (1) Any new, relevant information that You submit for consideration; and
- (2) Information presented during the hearing. Second level Grievance committee members and You will be permitted to question each other and any witnesses during the hearing. You will also be permitted to make a closing statement to the committee at the end of the hearing.

b. 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:

- (1) A statement of the second level committee's understanding of Your Grievance;
- (2) The basis of the second level committee's decision; and

- (3) 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.

3. Independent Review of Medical Necessity Determinations

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

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

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

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

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

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

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

DEFINITIONS

Defined terms are capitalized. When defined words are used in this EOC, they have the meaning set forth in this section.

1. **Actively At Work** – The performance of all of an Employee’s regular duties for the Employer on a regularly scheduled workday at the location where such duties are normally performed. Eligible Employees will be considered to be Actively At Work on a non-scheduled work day (which would include a scheduled vacation day) only if the Employee was Actively At Work on the last regularly scheduled work day.
2. **Acute** – An illness or injury that is both severe and of short duration.
3. **Administrative Services Agreement or ASA** – The arrangements between the administrator and the Employer, including any amendments, and any attachments to the ASA or this EOC.
4. **Advanced Radiological Imaging** – Services such as MRIs, MRAs, CAT scans, CT scans, PET scans, nuclear medicine and similar technologies.
5. **Behavioral Health Services** – Any services or supplies that are Medically Necessary and Appropriate to treat: a mental or nervous condition; alcoholism; chemical dependence; drug abuse or drug addiction.
6. **Billed Charges** – The amount that a Provider charges for services rendered. Billed Charges may be different from the amount that BlueCross determines to be the Maximum Allowable Charge for services.
7. **BlueCard PPO Participating Provider** – A physician, hospital, licensed skilled nursing facility, home health care Provider or other Provider contracted with other BlueCross and/or BlueShield Association (BlueCard PPO) Plans and/or Authorized by the Plan to provide Covered Services to Members.
8. **Calendar Year** – The period of time beginning at 12:01 A.M. on January 1st and ending 12:00 A.M. on December 31st.
9. **Care Management** – A program that promotes quality and cost effective coordination of care for Members with complicated medical needs, chronic illnesses, and/or catastrophic illnesses or injuries.
10. **CHIP** – The State Children’s Health Insurance Program established under title XXI of the Social Security Act (42 U.S.C. 1396 et. seq.)
11. **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.
12. **Coinsurance** – The amount, stated as a percentage of the Maximum Allowable Charge for a Covered Service that is the Member’s responsibility during the Calendar Year after any Deductible is satisfied. The Coinsurance percentage is calculated as 100%, minus the percentage Payment of the Maximum Allowable Charge as specified in Attachment C, Schedule of Benefits.

In addition to the Coinsurance percentage, You are responsible for the difference between the Billed Charges and the Maximum Allowable Charge for Covered Services if the Billed Charges of a Non-Contracted Provider or an Out-of-Network Provider are more than the Maximum Allowable Charge for such Services.

13. **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 caesarian section, ectopic pregnancy that is terminated, and spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

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

14. **Concurrent Review** – The process of evaluating care during the period when Covered Services are being rendered.
15. **Copayment** – The dollar amount specified in Attachment C, Schedule of Benefits, that You are required to pay directly to a Provider for certain Covered Services. You must pay such Copayments at the time You receive those Services.
16. **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.
17. **Covered Dependent** – A Subscriber’s family member who: (1) meets the eligibility requirements of this EOC; (2) has been enrolled for Coverage; and (3) for whom the Plan has received the applicable Payment for Coverage.
18. **Covered Family Members** – A Subscriber and his or her Covered Dependents.
19. **Covered Services, Coverage or Covered** – Those Medically Necessary and Appropriate services and supplies that are set forth in Attachment A of this EOC, (that is incorporated by reference). Covered Services are subject to all the terms, conditions, exclusions and limitations of the Plan and this EOC.
20. **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.
21. **Deductible** – The dollar amount, specified in Attachment C, Schedule of Benefits, that You must incur and pay for Covered Services during a Calendar Year before the Plan provides benefits for services.

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.

22. **Effective Date** - The date Your Coverage under this EOC begins.
23. **Eligible Providers** - All services must be rendered by a Practitioner or Provider type listed in the administrator’s Provider Directory of Network Providers, or as otherwise required by Tennessee law. The services provided by a Practitioner must be within his or her specialty or degree. All services must be rendered by the Practitioner or Provider, or the delegate actually billing for the Practitioner or Provider, and be within the scope of his or her licensure.

24. **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 a prudent layperson’s health in serious jeopardy.
- Examples of Emergency conditions include: (1) severe chest pain; (2) uncontrollable bleeding; or (3) unconsciousness.
25. **Emergency Care Services** – Those services and supplies that are Medically Necessary and Appropriate in the treatment of an Emergency.
26. **Employee** – A person who fulfills all eligibility requirements established by the Employer and the administrator.
27. **Employer** – A corporation, partnership, union or other entity that is eligible for group coverage under State and Federal laws; and that enters into an Agreement with the administrator to provide Coverage to its Employees and their Eligible Dependents.
28. **Enrollment Form** – A form or application that must be completed in full by the eligible Employee before he or she will be considered for Coverage under the Plan. The form or application may be in paper form, or electronic, as determined by the Plan Sponsor.
29. **ERISA** – The Employee Retirement Income Security Act of 1974, as amended.
30. **Hospital Confinement** – When You are treated as a registered bed patient at a Hospital or other Provider facility and incur a room and board charge.
31. **Hospital Services** – Covered Services that are Medically Appropriate to be provided by an Acute care Hospital.
32. **Incapacitated Child** – an unmarried child who is, and continues to be, both (1) incapable of self-sustaining employment by reason of intellectual disabilities (excluding mental illness) or physical handicap; and (2) chiefly dependent upon the Subscriber or Subscriber’s spouse for economic support and maintenance.
- a. If the child reaches this Plan’s limiting age while Covered under this Plan, proof of such incapacity and dependency must be furnished within 31 days of when the child reaches the limiting age.
 - b. Incapacitated dependents of Subscribers of new groups, or of Subscribers who are newly eligible under this Plan, are eligible for Coverage. 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.
33. **Investigational** – The definition of “investigational” is based on the BlueCross and BlueShield of Tennessee’s technology evaluation criteria. Any technology that fails to meet ALL of the following four criteria is considered to be investigational.
- The technology must have final approval from the appropriate governmental regulatory bodies, as demonstrated by:

- a. 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.
- b. Any approval that is granted as an interim step in the U.S. Food and Drug Administration's or any other federal governmental body's regulatory process is not sufficient.

The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes, as demonstrated by:

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.

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:
 - (1) 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:
 - (1) In reviewing the criteria above, the medical policy panel will consider physician specialty society recommendations, the view of prudent medical practitioners practicing in relevant clinical areas and any other relevant factors.

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

- a. Your medical records, or
- b. the protocol(s) under which proposed service or supply is to be delivered, or
- c. any consent document that You have executed or will be asked to execute, in order to receive the proposed service or supply, or
- d. the published authoritative medical or scientific literature regarding the proposed service or supply in connection with the treatment of injuries or illnesses such as those experienced by You, or
- e. regulations or other official publications issued by the FDA and HHS, or
- f. the opinions of any entities that contract with the Plan to assess and coordinate the treatment of Members requiring non-experimental or Investigational Services, or
- g. the findings of the BlueCross BlueShield Association Technology Evaluation Center or other similar qualified evaluation entities.

34. **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) a subsequent Open Enrollment Period.
35. **Lifetime Maximum** – The maximum amount of benefits for Covered Services rendered to You during Your lifetime.
36. **Maintenance Care** – Skilled services including skilled nursing visits, skilled nursing facility care, physical therapy, occupational therapy and/or speech therapy for chronic, static or progressive medical conditions where the services: (1) fail to contribute toward cure; (2) fail to improve unassisted clinical function; (3) fail to significantly improve health; and (4) are indefinite or long-term in nature.
37. **Maximum Allowable Charge** – The amount that the administrator, at its sole discretion, has determined to be the maximum amount payable for a Covered Service. That determination will be based upon the administrator's contract with a Network Provider or the amount payable based on the administrator's fee schedule for the Covered Services.
38. **Medicaid** – The program for medical assistance established under title XIX of the Social Security Act (42 U.S.C. 1396 et. seq.)
39. **Medical Director** – The physician designated by the administrator, or that physician's designee, who is responsible for the administration of the administrator's medical management programs, including its Authorization/Prior Authorization programs.
40. **Medically Appropriate** – Medically Appropriate – Services that have been determined by BlueCross, in its sole discretion, to be of value in the care of a specific Member. To be Medically Appropriate, a service must meet all of the following:
- 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.
41. **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.

42. **Medicare** – Title XVIII of the Social Security Act, as amended.
43. **Member, You, Your** – Any person enrolled as a Subscriber or Covered Dependent under the Plan.
44. **Member Payment** – The dollar amounts for Covered Services that You are responsible for as set forth in Attachment C, Schedule of Benefits, including Copayments, Deductibles, Coinsurance and Penalties. The administrator may require proof that You have made any required Member Payment.
45. **Network Benefit** – The Plan's payment level that applies to Covered Services received from a Network Provider. See Attachment C, Schedule of Benefits.
46. **Network Provider** – A Provider who has contracted with the administrator to provide access to benefits to Members at specified rates. Such Providers may be referred to as BlueCard PPO Participating Providers, Network hospitals, In-Transplant Network, etc.
47. **Non-Contracted Provider** – A Provider that renders Covered Services to a Member, in the situation where We have not contracted with that Provider type to provide those Covered Services. These Providers can change, as We contract with different Providers. A Provider's status as a Non-Contracted Provider, Network Provider, or Out-of-Network Provider can and does change. We reserve the right to change a Provider's status.
48. **Open Enrollment Period** – Those periods of time established by the Plan during which eligible Employees and their dependents may enroll as Members.
49. **Oral Appliance** – a device placed in the mouth and used to treat mild to moderate obstructive sleep apnea by repositioning or stabilizing the lower jaw, tongue, soft palate or uvula. An Oral Appliance may also be used to treat TMJ or TMD by stabilizing the jaw joint. An Oral Appliance is not the same as an occlusal splint, which is used to treat malocclusion or misalignment of teeth.
50. **Out-of-Network Provider** – Any Provider who is an eligible Provider type but who does not hold a contract with the administrator to provide Covered Services.
51. **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 Calendar Year.
52. **Payment** – The total payment for Coverage under the Plan, including amounts paid by You and the Employer for such Coverage.
53. **Payor(s)** – An insurer, health maintenance organization, no-fault liability insurer, self-insurer or other entity that provides or pays for a Member's health care benefits.
54. **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 the Plan payment for Covered Services.

55. **Periodic Health Screening** – An assessment of patient’s health status at intervals set forth in the administrator’s Medical Policy for the purpose of maintaining health and detecting disease in its early state. This assessment should include:
 - a. a complete history or interval update of the patient’s history and a review of systems; and
 - b. a physical examination of all major organ systems, and screening tests per the administrator’s Medical Policy.
56. **Practitioner** – A person licensed by the State to provide medical services.
57. **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.
58. **Prior Authorization, Authorization** – A review conducted by the administrator, prior to the delivery of certain services, to determine if such services will be considered Covered Services.
59. **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.
60. **Qualified Medical Child Support Order** – A medical child support order, issued by a court of competent jurisdiction or state administrative agency that creates or recognizes the existence of a child’s right to receive benefits for which a Subscriber is eligible under the Plan. Such order shall identify the Subscriber and each such child by name and last known mailing address; give a description of the type and duration of coverage to be provided to each child; and identify each health plan to which such order applies.
61. **Specialty Drugs** – Injectable, infusion and select oral medications that require complex care, including special handling, patient education and continuous monitoring. Specialty Drugs are listed on the administrator’s Specialty Drugs list. Specialty Drugs are categorized as provider-administered or self-administered..
62. **Subscriber** – An Employee who meets all applicable eligibility requirements, has enrolled for Coverage and who has submitted the applicable Payment for Coverage.
63. **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.
64. **Totally Disabled or Total Disability** – Either:
 - a. An Employee who is prevented from performing his or her work duties and is unable to engage in any work or other gainful activity for which he or she is qualified or could reasonably become qualified to perform by reason of education, training, or experience because of injury or disease; or
 - b. A Covered Dependent who is prevented from engaging in substantially all of the normal activities of a person of like age and sex in good health because of non-occupational injury or disease.
65. **Transplant Maximum Allowable Charge (TMAC)** – The amount that the administrator, in its sole discretion, has determined to be the maximum amount

payable for covered Services for Organ Transplants. Each type of Organ Transplant has a separate TMAC.

66. **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.
67. **Transplant Network Institution** – A facility or hospital that has contracted with the administrator (or with an entity on behalf of the administrator) to provide Transplant Services for some or all organ and bone marrow transplant procedures Covered under this EOC. For example, some hospitals might contract to perform heart transplants, but not liver transplants. An In-Transplant Network Institution is a Network Provider when performing contracted transplant procedures in accordance with the requirements of this EOC.
68. **Transplant Services** – Medically Necessary and Appropriate Services listed as Covered under the Transplant Services section in Attachment A of this EOC.
69. **Waiting Period** – The time that must pass before an Employee or Dependent is eligible to be Covered for benefits under the Plan.
70. **Well Child Care** – A routine visit to a pediatrician or other qualified Practitioner to include Medically Necessary and Medically Appropriate Periodic Health Screenings, immunizations and injections for children through age 5.
71. **Well Woman Exam** – A routine visit every Calendar Year to a Provider. The visit may include Medically Necessary and Medically Appropriate mammogram and cervical cancer screenings.

**ATTACHMENT A:
COVERED SERVICES AND EXCLUSIONS
EVIDENCE OF COVERAGE**

The Plan will pay the Maximum Allowable Charge for Medically Necessary and Appropriate services and supplies described below and provided in accordance with the reimbursement schedules set forth in Attachment C: Schedule of Benefits of this EOC, which is incorporated herein by reference. Charges in excess of the reimbursement rates set forth in the Schedule of Benefits are not eligible for reimbursement or payment.

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

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

Please also read Attachment B: Other Exclusions.

Your benefits are greater when You use Network Providers. BlueCross contracts with Network Providers. Network Providers have agreed to accept the Maximum Allowable Charge as 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 BlueCross. This means they may be able to charge You more than the Maximum Allowable Charge (the amount set by the administrator in its contracts with Network Providers). When You use an Out-of-Network Provider for Covered Services, You will be responsible for any difference between what the Plan pays and what the Out-of-Network Provider charges. This means that You may owe the Out-of-Network Provider a large amount of money.

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

Obtaining Prior Authorization is not a guarantee of Coverage. All provisions of the EOC must be satisfied before benefits for Covered Services will be provided. The administrator'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. Preventive Health Care Services

Medically Necessary and Appropriate Preventive Health Care Services.

1. Covered Services

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

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

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

- Annual Well Woman Exam, including cervical cancer screening, screening mammography at age 40 and older, and other USPSTF screenings with an A or B rating.
- Colorectal cancer screening for Members age 50-75.
- Prostate cancer screening for men age 50 and older.
- Screening and counseling in the primary care setting for alcohol misuse and tobacco use.
- Dietary counseling for adults with hyperlipidemia, hypertension, Type 2 diabetes, obesity, coronary artery disease and congestive heart failure.
- FDA-approved contraceptive methods, sterilization procedures and counseling for women with reproductive capacity. Note that prescription contraceptive products are covered under the Prescription Drug section.
- HPV testing once every 3 years for women age 30 and older.
- Lactation counseling by a trained provider during pregnancy or in the post-partum period, and manual breast pump.

Coverage may be limited as indicated in 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. Practitioner Office Services

Medically Necessary and Appropriate Covered Services in a Practitioner's office.

1. Covered Services
 - a. Diagnosis and treatment of illness or injury. (Note that allergy skin testing is Covered only in the practitioner office setting. Medically Necessary RAST (radioallergosorbent test), FAST (fluorescent allergosorbent test), or MAST (multiple radioallergosorbent test) allergy testing is Covered in the practitioner office setting and in a licensed laboratory.)
 - b. Injections and medications administered in a Practitioner's office, except Specialty Drugs. (See Provider Administered Specialty Drugs section for information on Coverage).
 - c. Second surgical opinions given by a Practitioner who is not in the same medical group as the Practitioner who initially recommended the Surgery.
 - d. Podiatry Services: charges for palliative services, including capsular or bone surgery for bunions; removal of the nail matrix due to disease, infection, fungus, surgical procedures or injections involving bones, nerves, muscles, or tendons of the foot or ankle; cutting or removal of corns, calluses or toenails due to a medical condition.
2. Exclusions
 - a. Routine foot care for the treatment of: (1) flat feet; (2) fallen arches; and (3) weak feet or chronic foot strain.
 - b. Rehabilitative therapies in excess of the limitations of the Therapeutic/ Rehabilitative benefit.
 - c. Dental procedures, except as otherwise indicated in this EOC.

C. 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 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.

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. All female Participants are covered. Limited to two ultrasounds per uncomplicated pregnancy. No limitations on ultrasounds for complicated pregnancies. Medically Necessary amniocentesis

is covered. Midwife services are covered. Natural birthing classes (Lamaze) are not covered.

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

D. Hospital Emergency Care Services

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

1. Covered Services
 - a. Medically Necessary and Appropriate Emergency services, supplies and medications necessary for the diagnosis and stabilization of Your Emergency condition.
 - b. Practitioner services.
2. Exclusions
 - a. Treatment of a chronic, non-Emergency condition where the symptoms have existed over a period of time, and a prudent layperson who possesses an average knowledge of health and medicine would not believe it to be an Emergency.
 - b. Services rendered for inpatient care or transfer to another facility once Your medical condition has stabilized, unless Prior Authorization is obtained from the administrator within 24 hours or the next working day.

E. 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 the patient.

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 the patient.
 - c. Services when You are not transported to a hospital.

F. Outpatient Facility Services

Medically Necessary and Appropriate diagnostics, therapies and Surgery occurring in an outpatient facility that includes outpatient Surgery centers, the outpatient center of a hospital, outpatient diagnostic centers, and certain surgical suites in a Practitioner's office. Prior Authorization is required for certain outpatient services must be obtained from the administrator, or benefits will be reduced or denied.

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

G. Family Planning and Reproductive Services

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

1. Covered Services
 - a. Benefits for family planning, history, physical examination, diagnostic testing and 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.
 - f. Services for the diagnosis and treatment of infertility. Subject to a maximum as shown in Attachment C: Schedule of Benefits.
 - g. Artificial insemination.
 - h. In vitro fertilization.
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) fallopian tube reconstruction; (2) uterine reconstruction; (3) assisted reproductive technology (ART) including but not limited to GIFT and ZIFT; (4) fertility injections; (5) fertility drugs, (6) services for follow-up care related to infertility treatments.
 - b. Services or supplies for the reversals of sterilizations.

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

H. Reconstructive Surgery

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

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

I. Skilled Nursing/Rehabilitative Facility Services

Medically Necessary and Appropriate Inpatient care provided to Members requiring medical, rehabilitative or nursing care in a restorative setting. Services shall be considered separate and distinct from the levels of Acute care rendered in a hospital setting, or custodial or functional care rendered in a nursing home. Prior Authorization for Covered Services must be obtained from the administrator, 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 Attachment C: Schedule of Benefits.
2. Exclusions
 - a. Custodial or domiciliary services.
 - b. Skilled Nursing services not received in a Medicare certified skilled nursing facility.

J. Therapeutic/Rehabilitative Services

Medically Necessary and Appropriate therapeutic and rehabilitative services performed in a Practitioner's office, outpatient facility or home health setting and intended to restore or improve bodily function.

1. Covered Services

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

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

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

- b. Coverage is limited as indicated in Attachment C: Schedule of Benefits.
- c. 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.
- d. Services received during an inpatient hospital, skilled nursing or rehabilitative facility stay are Covered as shown in the inpatient hospital, skilled nursing or rehabilitative facility section, and are not subject to the therapy visit limits.

2. Exclusions

- a. Treatment beyond what can reasonably be expected to significantly improve health, including therapeutic treatments for ongoing maintenance or palliative care.
- b. Enhancement therapy that is designed to improve Your physical status beyond Your pre-injury or pre-illness state.
- c. Complementary and alternative therapeutic services, including, but not limited to: (1) massage therapy; (2) acupuncture; (3) craniosacral therapy; (4) 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.
- d. Modalities that do not require the attendance or supervision of a licensed therapist. These include, but are not limited to: (1) activities that are primarily social or recreational in nature; (2) simple exercise programs; (3) hot and cold packs applied in the absence of associated therapy modalities; (4) repetitive exercises or tasks that You can perform without a therapist, in a home setting; (5) routine dressing changes; and (6) custodial services that can ordinarily be taught to You or a caregiver.
- e. Behavioral therapy, play therapy, communication therapy, and therapy for self-correcting language dysfunctions as part of speech therapy, physical therapy or occupational therapy programs. Behavioral therapy and play therapy for behavioral health diagnoses may be Covered under the Behavioral Health section (if applicable to Your Group Coverage).

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

K. Organ Transplants

As soon as Your Provider tells You that You might need a transplant, You or Your Provider must contact the administrator's Transplant Case Management department.

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

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

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

1. Prior Authorization Procedures

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

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

2. Covered Services

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

- a. Medically Necessary and Appropriate services and supplies, otherwise Covered under this EOC.
- b. Medically Necessary and Appropriate services and supplies for each listed organ transplant are Covered only when Transplant Case Management approves a transplant. **Not all Network Providers are in Our Transplant Network. Please check with a Transplant case manager to see which hospitals are in Our Transplant network.**
- c. Travel expenses for Your evaluation prior to a Covered Procedure, and to and from the site of a Covered Procedure by: (1) private car; (2) ground or air ambulance; or (3) public transportation. This includes travel expenses for You and a companion. The companion must be Your spouse, family member, Your

guardian or other person approved by Transplant Case Management. In order to be reimbursed, travel must be approved by Transplant Case Management. In many cases, travel will not be approved for kidney transplants..

- (1) Travel by private car is limited to reimbursement at the IRS mileage rate in effect at the time of travel to and from a facility in the Transplant Network.
 - (2) Meals and lodging expenses, limited to \$150 daily.
 - (3) The aggregate limit for travel expenses is \$10,000 per Covered Procedure.
 - (4) Travel Expenses are Covered only if You go to an In-Transplant Network Institution;
- d. Donor Organ Procurement. If the donor is not a Member, Covered Services for the donor are limited to those services and supplies directly related to the Transplant Service itself: (1) testing for the donor's compatibility; (2) removal of the organ from donor's body; (3) preservation of the organ; (4) transportation of the organ to the site of transplant; and (5) donor follow-up care. Services are Covered only to the extent not covered by other health coverage. The search process and securing the organ are also Covered under this benefit. Complications of donor organ procurement are not Covered. The cost of Donor Organ Procurement is included in the total cost of Your Organ Transplant.

3. Conditions/Limitations

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

- a. You or Your physician must notify Transplant Case Management prior to Your receiving any Transplant Service, including pre-transplant evaluation, and obtain Prior Authorization. If Transplant Case Management is not notified, the transplant and related procedures will not be Covered at all;
- b. Transplant Case Management will coordinate all transplant services, including pre-transplant evaluation. You must cooperate with 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.**
 - (1) In-Transplant Network transplants. You have the transplant performed at an In-Transplant Network Provider. You receive the highest level of reimbursement for Covered Services. The Plan will reimburse the In-Transplant Network Provider at the benefit level listed in Attachment C: Schedule of Benefits, at the Transplant Maximum Allowable Charge. The In-Transplant Network Provider cannot bill You for any amount over

- the Transplant Maximum Allowable Charge for the transplant, which limits Your liability;
- (2) 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 levels 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;
 - (3) 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: Network and Out-of-Network:
 - (1) 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;
 - (2) 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 an In-Transplant Network Institution, the transplant expenses specified in Attachment C: Schedule of Benefits are Covered

4. Exclusions

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

- a. Transplants 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 are covered under any private or public research fund, regardless of whether You applied for or received amounts from such fund;
- g. Any non-human, artificial or mechanical organ;
- h. Payment to an organ donor or the donor's family as compensation for an organ, or payment required to obtain written consent to donate an organ;
- i. Donor services including screening and assessment procedures that have not received Prior Authorization from Us;
- j. Removal of an organ from a Member for purposes of transplantation into another person, except as Covered by the Donor Organ Procurement provision as described above;
- k. Harvest, procurement, and storage of stem cells, whether obtained from peripheral blood, cord blood, or bone marrow when reinfusion is not scheduled or anticipated to be scheduled within an appropriate time frame for the patient's covered stem cell transplant diagnosis;
- l. Other non-organ transplants (e.g., cornea) are not Covered under this Section, but may be Covered as an inpatient Hospital Service or outpatient facility service, if Medically Necessary.

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

L. Dental Services

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

- 1. Covered Services
 - a. Dental services and oral surgical care to treat intraoral cancer, or to treat accidental injury to the jaw, sound natural teeth, mouth, or face, due to external trauma.
 - 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 conditions listed below is met.
 - (1) Complex oral Surgical Procedures that have a high probability of complications due to the nature of the Surgery;

- (2) Concomitant systemic disease for which the patient is under current medical management and that significantly increases the probability of complications;
- (3) Mental illness or behavioral condition that precludes dental Surgery in the office;
- (4) Use of general anesthesia and the Member's medical condition requires that such procedure be performed in a hospital; or
- (5) Dental treatment or Surgery performed on a Member 8 years of age or younger, where such procedure cannot be provided safely in a dental office setting.

Prior Authorization for inpatient services is required.

- c. Extraction of impacted teeth, including wisdom teeth.
- d. Oral Appliances to treat obstructive sleep apnea, if Medically Necessary.

2. Exclusions

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

M. Temporomandibular Joint Dysfunction (TMJ)

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

1. Covered Services

- a. Diagnosis and treatment 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 exam; (2) office visit; (3) x-rays; (4) diagnostic study casts; (5) medications; and (6) appliances to stabilize jaw joint.

2. Exclusions

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

by biting and chewing; (14) treatment of teeth roots; and (15) treatment of gums surrounding the teeth.

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

N. Diagnostic Services

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

1. Covered Services

- a. Imaging services ordered by a Practitioner, including x-ray, ultrasound, bone density test, and Advanced Radiological Imaging Services. Advanced Radiological Imaging Services include MRIs, CT scans, PET scans, nuclear cardiac imaging. Maternity ultrasounds are limited to two ultrasounds per uncomplicated pregnancy. This limit does not apply to complicated pregnancies.
- b. Diagnostic laboratory services ordered by a Practitioner.
- c. Genetic testing if: (1) for BRCA testing with family history; or (2) related to cancer treatment.

2. Exclusions

- a. Diagnostic services that are not Medically Necessary and Appropriate.
- b. Diagnostic services not ordered by a Practitioner.

O. Durable Medical Equipment

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 Durable Medical 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, obsolescence or 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 Durable Medical Equipment.
 - b. Unnecessary repair, adjustment or replacement or duplicates of any such Durable Medical 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, pools, 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.

P. 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 incident to a Practitioner’s services or on a Practitioner’s order.
 - d. The replacement of Covered items required as a result of growth, normal wear and tear, defects or 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. Benefits for eyeglasses or contact lens are limited as indicated in Attachment C: Schedule of Benefits.
 - g. Hearing aids for Members under age 18, limited as indicated in Attachment C: Schedule of Benefits.
 - h. Orthopedic Shoes and Foot Orthotics. Charges for palliative treatment, custom molded orthotics if Medically Necessary and prescribed by a Network provider and approved in advance and purchased by a Durable Medical Equipment

provider. Includes replacement if Medically Necessary and not a result of loss, theft or damage. Excludes heel lifts, arch supports and foot pads.

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 has been provided following cataract Surgery.

Q. Diabetes Treatment

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

1. Covered Services
 - a. Blood glucose monitors, including monitors designed for the legally blind.
 - b. Test strips for blood glucose monitors.
 - c. Visual reading and urine test strips.
 - d. Insulin.
 - e. Injection aids.
 - f. Syringes.
 - g. Lancets.
 - h. Oral hypoglycemic agents.
 - i. Glucagon emergency kits.
 - j. Injectable incretin mimetics (e.g., Exenatide/Byetta) when used in conjunction with selected Prescription Drugs for the treatment of diabetes.
 - k. Insulin pumps, infusion devices, and appurtenances, not subject to the benefit limit for Durable Medical Equipment indicated in Attachment C: Schedule of Benefits. Insulin pump replacement is Covered only for pumps older than 48 months and if the pump cannot be repaired.
 - l. Podiatric appliances for prevention of complications associated with diabetes.
2. Exclusions
 - a. Treatments or supplies that are not prescribed and certified by a Practitioner as being Medically Necessary.
 - b. Supplies not required by state statute.

R. Supplies

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.

S. Home Health Care Services

Medically Necessary and Appropriate services and supplies authorized by the Plan and 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 benefit).
- d. Medical social services.
- e. Dietary guidance.

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.
- b. Services that were not Authorized by the Plan.

T. 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) routine transportation; (6) funeral or financial counseling.

U. Behavioral Health Services

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

1. Covered Services
 - a. Inpatient and outpatient services for care and treatment of mental health disorders and substance abuse disorders.
2. Exclusions
 - a. Pastoral counseling.
 - b. Marriage and family counseling without a behavioral health diagnosis.
 - c. Vocational and educational training and/or services.
 - d. Custodial or domiciliary care.
 - e. Conditions without recognizable ICD-9 diagnostic classification, such as adult child of alcoholics (ACOA), and co-dependency and self-help programs.
 - f. Sleep disorders.
 - g. Services related to mental retardation.
 - h. Habilitative as opposed to rehabilitative services, i.e., services to achieve a level of functioning the individual has never attained.
 - i. Court ordered examinations and treatment, unless Medically Necessary.
 - j. Pain management.
 - k. Hypnosis or regressive hypnotic techniques.
 - l. Charges for telephone consultations, missed appointments, completion of forms, or other administrative services

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

V. Vision

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

1. Covered Services

- a. Services and supplies for the diagnosis and treatment of diseases and injuries to the eye.
- b. First set of eyeglasses or contact lens required to adjust for vision changes due to cataract surgery and obtained within 6 months following the surgery.

2. Exclusions

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

- a. 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.

W. Prescription Drugs

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

1. Covered Services

- a. Treatment of phenylketonuria (PKU), including special dietary formulas while under the supervision of a Practitioner.
- b. Pharmaceuticals that are dispensed or intended for use while You are confined in a hospital, skilled nursing facility or other similar facility.

2. Exclusions

- a. This Plan does not provide coverage for prescription drugs except as indicated above.
- b. Those pharmaceuticals that may be purchased without a prescription.

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 Services.
2. Services or supplies that are determined to be not Medically Necessary and Appropriate.
3. Services or supplies that are Investigational in nature including, but not limited to: (1) drugs; (2) biologicals; (3) medications; (4) devices; and (5) treatments.
4. Illness or injury resulting from war that occurred before Your Coverage began under this EOC and that is covered by: (1) veteran's benefit; or (2) other coverage for which You are legally entitled.
5. Self-treatment or training.
6. Staff consultations required by hospital or other facility rules.
7. Services that are free.
8. Services or supplies for the treatment of work related illness or injury, regardless of the presence or absence of workers' compensation coverage. This exclusion does not apply to injuries or illnesses of an Employee who is (1) a sole-proprietor of the Employer; (2) a partner of the Employer; or (3) a corporate officer of the Employer, provided the officer filed an election not to accept Workers' Compensation with the appropriate government department.
9. Personal, physical fitness, recreational and convenience items and services such as: (1) barber and beauty services; (2) television; (3) air conditioners; (4) humidifiers; (5) air filters; (6) heaters, (7) physical fitness equipment; (8) saunas; (9) whirlpools; (10) water purifiers; (11) swimming pools; (12) tanning beds; (13) weight loss programs; (14) physical fitness programs; or (15) devices and computers to assist in communication or speech; or (16) self-help devices that are not primarily medical in nature, even if ordered by a Practitioner.
10. Services or supplies received before Your effective date for Coverage with this Plan.
11. Services or supplies related to a Hospital Confinement received before Your effective date for Coverage with this Plan.
12. Services or supplies received after Your Coverage under this Plan ceases for any reason. This is true even though the expenses relate to a condition that began while You were Covered. The only exception to this is described under the Extended Benefits section.
13. Services or supplies received in a dental or medical department maintained by or on behalf of the Employer, mutual benefit association, labor union or similar group.
14. Services or charges to complete a claim form or to provide medical records or other administrative functions. We will not charge You or Your legal representative for statutorily required copying charges;
15. Charges for failure to keep a scheduled appointment;
16. Charges for telephone consultations, e-mail or web based consultations, except as may be provided for by specially arranged Care Management programs or emerging

health care programs as described in the Prior Authorization, Care Management, Medical Policy and Patient Safety section of this EOC;

17. Court ordered examinations and treatment, unless Medically Necessary.
18. Room, board and general nursing care rendered on the date of discharge, unless admission and discharge occur on the same day.
19. Charges in excess of the Maximum Allowable Charge for Covered Services.;
20. Any service stated in Attachment A as a non-Covered Service or limitation.
21. Charges for services performed by You or Your spouse, or Your or Your spouse's parent, sister, brother or child.
22. Any charges for handling fees.
23. Nicotine replacement therapy and aids to smoking cessation including, but not limited to, patches.
24. Human growth hormones, unless covered under the Plan's Prescription Drug program.
25. Safety items, or items to affect performance primarily in sports-related activities.
26. Services or supplies, including bariatric Surgery, for weight loss or to treat obesity, even if You have other health conditions that might be helped by weight loss or reduction of obesity. This exclusion applies whether You are of normal weight, overweight, obese or morbidly obese.
27. Services or supplies related to treatment of complications (except Complications of Pregnancy) that are a direct or closely related result of a Member's refusal to accept treatment, medicines, or a course of treatment that a Provider has recommended or has been determined to be Medically Necessary, including leaving an inpatient medical facility against the advice of the treating physician.
28. Cosmetic services, except as appropriate per medical policy. This exclusion also applies to surgeries to improve appearance following a prior Surgical Procedure, even if that prior procedure was a Covered Service. Cosmetic services include, but are not limited to: (1) removal of tattoos; (2) facelifts; (3) keloid removal; (4) dermabrasion; (5) chemical peels; (6) breast augmentation; (7) lipectomy; (8) body contouring or body modeling; (9) injections to smooth wrinkles, including but not limited to Botox; (10) laser resurfacing; (11) sclerotherapy injections, laser or other treatment for spider veins and varicose veins, except as appropriate per medical policy; (12) piercing ears or other body parts; (13) rhytidectomy or rhytidoplasty (Surgery for the removal or elimination of wrinkles); (14) rhinoplasty; (15) panniculectomy; (16) abdominoplasty; (17) thighplasty; and (18) brachioplasty;
29. Browplasty;
30. Charges relating to surrogate pregnancy, including but not limited to maternity and delivery charges, whether or not the surrogate mother is Covered under this plan.
31. Sperm preservation.
32. Services or supplies for orthognathic Surgery, a discipline to specifically treat malocclusion. Orthognathic Surgery is not Surgery to treat cleft palate.
33. Services or supplies for Maintenance Care.

34. Services or supplies to treat sexual dysfunction, regardless of cause, including but not limited to erectile dysfunction (e.g. Viagra), delayed ejaculation, anorgasmia and decreased libido.
35. Services or supplies related to complications of cosmetic procedures, complications of bariatric Surgery; re-operation of bariatric Surgery or body remodeling after weight loss.
36. Cranial orthosis, including helmet or headband, for the treatment of non-synostotic plagiocephaly.
37. 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;
38. Vagus nerve stimulation for the treatment of depression;
39. Balloon sinuplasty for treatment of chronic sinusitis;
40. Treatment for benign gynecomastia;
41. Treatment for hyperhidrosis;
42. Intradiscal annuloplasty to treat discogenic back pain. This procedure provides controlled delivery of heat to the intervertebral disc through an electrode or coil.

ATTACHMENT C: PPO SCHEDULE OF BENEFITS

Group Name: City of Murfreesboro

Group Number: 125224

Effective Date: 1/1/2015

Network: P

PLEASE READ THIS IMPORTANT STATEMENT: Network benefits apply to services received from Network Providers and Non-Contracted Providers.

Out-of-Network benefit percentages apply to BlueCross Maximum Allowable Charge, not to the Provider’s billed charge. When using Out-of-Network Providers, You must pay the difference between the Provider’s price and the Maximum Allowable Charge. This amount can be substantial. **For more information, please refer to the definitions of Coinsurance and Maximum Allowable Charge in the Definitions section of this EOC.**

PPO	Network Services received from Network Providers	Out-of-Network Services received from Out-of-Network Providers
Maximum	Unlimited	
Infertility treatment	\$2,000 per Calendar Year \$15,000 per lifetime	
Deductible ¹		
Individual	\$500	\$1,000
Family	\$1,000	\$2,000
Out-of-Pocket Maximum ²		
Individual	\$1,500	\$3,000
Family	\$3,000	\$6,000

HRA	Network Services received from Network Providers	Out-of-Network Services received from Out-of-Network Providers
Maximum	Unlimited	
Infertility treatment	\$2,000 per Calendar Year \$15,000 per lifetime	
Deductible ¹		
Individual	\$1,500	\$3,000
Family	\$3,000	\$6,000
Out-of-Pocket Maximum ²		
Individual	\$3,000	\$6,000
Family	\$6,000	\$12,000

1. DEDUCTIBLE

There are 2 separate Deductible amounts – one for Network Providers and one for Out-of-Network Providers.

Satisfying the Deductible under the Network Provider benefits does not satisfy the Deductible for the Out-of-Network Provider benefits, and vice versa.

The Deductible will apply to the Individual Out-of-Pocket and Family Out-of-Pocket Maximum(s).

2. OUT-OF-POCKET

There are 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 Out-of-Pocket Maximum, Network Providers, is satisfied, 100% of available benefits is payable for other Covered Services from Network Providers incurred by the Member during the remainder of that Calendar Year, excluding applicable Penalties, and any balance of charges (the difference between Billed Charges and the Maximum Allowable Charge).

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

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Preventive Health Care Services		
Well Child Care (to age 6)	100%	100% of the Maximum Allowable Charge
Well Woman Exam	100%	100% of the Maximum Allowable Charge
Mammogram, Cervical cancer Screening and Prostate cancer Screening	100%	100% of the Maximum Allowable Charge
Immunizations	100%	100% of the Maximum Allowable Charge
Preventive/Well Care Services Includes preventive health exam, screenings and counseling services. Alcohol misuse and tobacco use counseling limited to 8 visits annually; must be provided in the primary care setting; Dietary counseling for adults with hyperlipidemia, hypertension, Type 2 diabetes, coronary artery disease and congestive heart failure limited to 6 visits annually.	100%	100% of the Maximum Allowable Charge
Other Well Care Screenings, age 6 and above including flexible sigmoidoscopy or colonoscopy	100%	100% of the Maximum Allowable Charge
Lactation counseling by a trained provider during pregnancy or in the post-partum period. Limited to one visit per pregnancy.	100%	100% of the Maximum Allowable Charge
Manual Breast Pump, limited to one per pregnancy	100%	100% of the Maximum Allowable Charge
FDA-approved contraceptive methods, sterilization procedures and counseling for women with reproductive capacity.	100%	100% of the Maximum Allowable Charge

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Services Received at the Practitioner's Office		
Office Exams and Consultations		
<p>Diagnosis and treatment of illness or injury</p> <p>Primary Care Practitioner types (Internal Medicine, General Practice, Family Medicine, Pediatrics, Obstetrics & Gynecology)</p> <p>All other Practitioners</p> <p>The Copayment for a Physician Assistant or Nurse Practitioner may be based on the Provider type of the delegate physician.</p>	<p>Primary Care Practitioners: 100 % after \$20 Copayment</p> <p>Specialists: 100 % after \$25 Copayment</p>	<p>50 % of the Maximum Allowable Charge after Deductible</p>
<p>Maternity care</p> <p>The Copayment applies to the initial office visit to confirm pregnancy. For benefits for subsequent prenatal visits, postnatal visits and the physician delivery charge, see Inpatient Hospital Stays, including maternity stays in the section Services Received at a Facility. Benefits for specialty care, even if related to pregnancy, are considered as any other illness, and a separate Copayment will apply.</p>	<p>Primary Care Practitioners: 100% after \$20 Copayment (Copayment applies to first visit only)</p> <p>Specialists: 100 % after \$25 Copayment (Copayment applies to first visit only)</p>	<p>50 % of the Maximum Allowable Charge after Deductible</p>
Injections and Immunizations		
<p>Allergy injections and allergy extract</p>	<p>No Additional Copayment</p>	<p>50 % of the Maximum Allowable Charge after Deductible</p>
<p>Provider-administered Specialty Drugs</p>	<p>100%</p>	<p>50 % of the Maximum Allowable Charge after Deductible</p>
<p>All other medicine injections, excluding Specialty Drugs.</p> <p>For surgery injections, please see Office Surgery under the Other office procedures, services or supplies section.</p>	<p>100% after Deductible</p>	<p>50 % of the Maximum Allowable Charge after Deductible</p>
Diagnostic Services and Preventive Screenings (e.g. x-ray and labwork)		
<p>Allergy Testing</p>	<p>100% after \$25 Copayment</p>	<p>50 % of the Maximum Allowable Charge after \$50 Copayment</p>

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Services Received at the Practitioner's Office		
Advanced Radiological Imaging Includes CAT scans, CT scans, MRIs, PET scans, nuclear medicine and other similar technologies.	80 %	50 % of the Maximum Allowable Charge
All Other Diagnostic Services for illness or injury	80 %	50 % of the Maximum Allowable Charge
Maternity care diagnostic services Ultrasounds limited to 2 per non-complicated pregnancy; unlimited for a complicated pregnancy.	No Additional Copayment	50 % of the Maximum Allowable Charge after Deductible

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Services Received at the Practitioner's Office		
Other office procedures, services or supplies		
<p>Office Surgery, including anesthesia, performed in and billed by the Practitioner's office Primary Care Practitioner types</p> <p>Specialists The Copayment for a Physician Assistant or Nurse Practitioner may be based on the Provider type of the delegate physician.</p> <p>Some procedures require Prior Authorization. Call Our consumer advisors to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, benefits may be reduced for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). (See the Prior Authorization section for more information.) Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization.</p> <p>Surgeries include incisions, excisions, biopsies, injection treatments, fracture treatments, applications of casts and splints, sutures, and invasive diagnostic services (e.g., colonoscopy, sigmoidoscopy and endoscopy).</p>	<p>80 % after Deductible</p> <p>80 % after Deductible</p>	<p>50 % of the Maximum Allowable Charge after Deductible</p>
<p>Non-routine treatments: Includes renal dialysis, radiation therapy, chemotherapy and infusions. Does not apply to Specialty Drugs. See Provider-Administered Specialty Drugs section for applicable benefit.</p>	<p>Primary Care Practitioners: 100% after \$20 Copayment</p> <p>Specialists: 100% after \$25 Copayment</p>	<p>50 % of the Maximum Allowable Charge after Deductible</p>
<p>All Other Office services</p>	<p>80 % after Deductible</p>	<p>50 % of the Maximum Allowable Charge after Deductible</p>

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Services Received at a Facility		
<p>Inpatient Hospital Stays, including maternity stays (Please refer the the statement of rights under the Newborns' and Mothers' Health Protection Act section on a following page): Prior Authorization required. Benefits may be reduced for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers) when Prior Authorization is not obtained. (See the Prior Authorization section for more information.) Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization.</p>		
Facility charges	80 % after Deductible	50 % of the Maximum Allowable Charge after Deductible
Practitioner charges (including global maternity delivery charges billed as inpatient service and newborn physician visits)	100% after Deductible	50 % of the Maximum Allowable Charge after Deductible
Skilled Nursing or Rehab Facility stays		
<p>(Limited to 60 days per Calendar Year) Prior Authorization required. Benefits may be reduced for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers) when Prior Authorization is not obtained. (See the Prior Authorization section for more information.) Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization.</p>		
Facility charges	80 % after Deductible	50 % of the Maximum Allowable Charge after Deductible
Practitioner charges	80 % after Deductible	50 % of the Maximum Allowable Charge after Deductible
Hospital Emergency Care Services		
Emergency Room charges (Copayment waived if admitted)	100 % after \$250 Copayment per visit	100 % of the Maximum Allowable Charge after \$250 Copayment per visit
Advanced Radiological Imaging Services Includes CAT scans, CT scans, MRIs, PET scans, nuclear medicine and other similar technologies.	100%	100% of the Maximum Allowable Charge
All Other Hospital Charges	100%	100% of the Maximum Allowable Charge
Practitioner Charges	100%	100% of the Maximum Allowable Charge

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Services Received at a Facility		
Urgent Care Facility Services		
Facility charges	100% after \$35 Copayment per visit	50% of the Maximum Allowable Charge after Deductible
Practitioner charges	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
<p>Outpatient Facility Services Outpatient Surgery Some procedures require Prior Authorization. Call Our consumer advisors to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, benefits may be reduced for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). (See the Prior Authorization section for more information.) Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization. Surgeries include invasive diagnostic services (e.g., colonoscopy, sigmoidoscopy).</p>		
Facility charges	80 % after Deductible	50 % of the Maximum Allowable Charge after Deductible
Practitioner charges	80 % after Deductible	50 % of the Maximum Allowable Charge after Deductible
Outpatient Diagnostic Services and Outpatient Screenings		
<p>Advanced Radiological Imaging Includes CAT scans, CT scans, MRIs, PET scans, nuclear medicine and other similar technologies.</p>	80 %	50 % of the Maximum Allowable Charge
All other Diagnostic Services for illness or injury	80 %	50 % of the Maximum Allowable Charge
Maternity care diagnostic services	100 %	50 % of the Maximum Allowable Charge after Deductible

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Services Received at a Facility		
Other Outpatient Services		
<p>Non-routine treatments:</p> <p>Includes renal dialysis, radiation therapy, chemotherapy and infusions.</p> <p>Includes Provider Administered Specialty Drugs.</p>	<p>100% after Deductible</p>	<p>50 % of the Maximum Allowable Charge after Deductible</p>
<p>All Other services received at an outpatient facility, including chemotherapy, radiation therapy, injections, infusions, and renal dialysis</p>	<p>Primary Care Practitioners:</p> <p>100%</p> <p>Specialists:</p> <p>100%</p>	<p>50 % of the Maximum Allowable Charge after Deductible</p>

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Other Services		
Ground or air Ambulance	80 % after Deductible	80 % of the Maximum Allowable Charge after Deductible
Home Health Care Services, including home infusion therapy Prior Authorization is required for skilled nurse visits in the home. Physical, speech or occupational therapy provided in the home do not require Prior Authorization.	80 % after Deductible	50 % of the Maximum Allowable Charge after Deductible
Hospice Care Limited to 180 days per lifetime	80 % after Deductible	50 % of the Maximum Allowable Charge after Deductible
Therapy Services: Physical, speech, and occupational therapy limited to 20 visits per therapy type per Calendar Year; Chiropractic/Manipulative therapy limited to 60 visits per Calendar Year;	100% after \$25 Copayment	100% of the Maximum Allowable Charge after \$50 Copayment
Cardiac rehab therapy limited to 36 visits per Calendar Year	100% after \$25 Copayment	50 % of the Maximum Allowable Charge after Deductible
Respiratory/Pulmonary rehab therapy Unlimited visits per Calendar Year	Primary Care Practitioners: 100% after \$20 Copayment Specialists: 100% after \$25 Copayment	50 % of the Maximum Allowable Charge after Deductible
DME, Orthotics and Prosthetics	80 % after Deductible	50 % of the Maximum Allowable Charge after Deductible
Supplies	80 % after Deductible	50 % of the Maximum Allowable Charge after Deductible
Private duty nursing	80% after Deductible	50% of the Maximum Allowable Charge after Deductible
Electric breast pumps – Ameda Purely Yours Breast Pump and Carry All – Lansinoh Double Electric Breast Pump	100%	50% of the Maximum Allowable Charge after Deductible

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Other Services – Hearing Aids		
Hearing Aids for Members under age 18 Limited to one per ear every 3 years (as determined by Your Annual Benefit Period).	80% after Deductible	50% of the Maximum Allowable Charge after Deductible

Covered Services	Benefits for Covered Services received from Network Providers		Benefits for Covered Services received from Out-of-Network Providers
Organ Transplant Services			
<p>Organ Transplant Services, all transplants except kidney All Organ Transplants require Prior Authorization. Benefits will be denied without Prior Authorization. Transplant Network Providers are different from Network Providers for other services. Call customer service before any pre-transplant evaluation or other Transplant Service is performed to request Authorization, and to obtain information about Transplant Network Providers. Network Providers that are not in the Transplant Network may balance bill the Member for amounts over TMAC not Covered by the Plan.</p>	<p>In-Transplant Network benefits:</p> <p>80 % after Network Deductible, Network Out-of-Pocket Maximum applies.</p>	<p>Network Providers not in Our Transplant Network (Network Providers not in our Transplant Network include Network Providers in Tennessee and BlueCard PPO Providers outside Tennessee):</p> <p>80 % of Transplant Maximum Allowable Charge (TMAC) after Network Deductible, Network Out-of-Pocket Maximum applies, amounts over TMAC do not apply to the Out-of-Pocket Maximum and are not Covered.</p>	<p>Out-of-Network Providers:</p> <p>50 % of Transplant Maximum Allowable Charge (TMAC), after Out-of-Network Deductible, Out-of-Network Out-of-Pocket Maximum applies, amounts over TMAC do not apply to the Out-of-Pocket and are not Covered.</p>
<p>Organ Transplant Services, kidney transplants</p> <p>All Organ Transplants require Prior Authorization. Benefits will be denied without Prior Authorization. Call customer service before any pre-transplant evaluation or other Transplant Service is performed to request Authorization.</p>	<p>80 % after Network Deductible; Network Out-of-Pocket Maximum applies.</p>		<p>50 % of Maximum Allowable Charge (MAC), after Out-of-Network Deductible, Out-of-Network Out-of-Pocket Maximum applies, amounts over MAC do not apply to the Out-of-Pocket and are not Covered.</p>

GENERAL LEGAL PROVISIONS

INDEPENDENT LICENSEE OF THE BLUECROSS BLUESHIELD ASSOCIATION

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

RELATIONSHIP WITH NETWORK PROVIDERS

A. Independent Contractors

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

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

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

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

B. Termination of Providers’ Participation

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

C. Provider Directory

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

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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

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

in a manner determined in consultation with the attending physician and the patient. The Coverage may be subject to Coinsurance and Deductibles consistent with those established for other benefits. Please refer to the Covered Services section of this EOC for details.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

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

SUBROGATION AND RIGHT OF REIMBURSEMENT

A. Subrogation Rights

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

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

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

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

B. Priority Right of Reimbursement

Separate and apart from the Plan's right of subrogation, the Plan shall have first lien and right to reimbursement. The Plan's first lien supercedes any right that You may have to be "made whole". In other words, the Plan is entitled to the right of first reimbursement out of any recovery You might procure regardless of whether You have received compensation for any of Your damages or expenses, including Your attorneys' fees or costs. This priority right of reimbursement supersedes Your right to be made whole from any recovery, whether full or partial. In addition, You agree to do nothing to prejudice or oppose the Plan's right to subrogation and reimbursement and You acknowledge that the Plan precludes operation of the "made-whole", "attorney-fund", and "common-fund" doctrines. You agree to reimburse the Plan 100% first for any and all benefits provided through the Plan, and for any costs of recovering such amounts from those third parties from any and all amounts recovered through:

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

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

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

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

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

Notice and Cooperation

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

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

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

Legal Action and Costs

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

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

Settlement or Other Compromise

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

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

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

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

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY. THEN, KEEP IT ON FILE FOR REFERENCE

LEGAL OBLIGATIONS

Employer and some subsidiaries and affiliates are required to maintain the privacy of all health plan information, which may include Your: name, address, diagnosis codes, etc. as required by applicable laws and regulations (hereafter referred to as “legal obligations”); provide this notice of privacy practices to all Members, inform Members of the Employer’s legal obligations; and advise Members of additional rights concerning their health plan information. Employer must follow the privacy practices contained in this notice from its effective date until this notice is changed or replaced.

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

You may request a copy of this notice of privacy practices at any time by contacting the Employer at the address at the end of this notice.

ORGANIZATIONS COVERED BY THIS NOTICE

This notice applies to the privacy practices of the Employer and may apply to some subsidiaries and affiliates. Health plan information about Members may be shared among these organizations as needed for treatment, payment or healthcare operations. As the Employer procures or creates new business lines, they may be required to follow the terms defined in this notice of privacy practices.

Subsidiaries or affiliates that do not receive or have access to Your health plan information and are to be excluded from this notice of privacy practices include: The non-healthcare components of the Employer.

USES AND DISCLOSURES OF YOUR INFORMATION

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

1. **TREATMENT:** Your health plan information may be disclosed to a healthcare provider that asks for it to provide treatment.
2. **PAYMENT:** Your health plan information may be used or disclosed to pay claims for services or to coordinate benefits that are covered under Your health insurance policy.
3. **HEALTH CARE OPERATIONS:** Your health plan 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, fraud prevention and investigation, wellness, disease management, and for other similar administrative purposes.

4. **AUTHORIZATIONS:** You may provide written authorization to use Your health plan 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. Employer cannot use or disclose Your health plan information except as described in this notice, without Your written authorization. Examples of where an authorization would be required include: 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 this notice.
5. **PERSONAL REPRESENTATIVE:** Your health plan 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 that the Employer may do so, as described in the Individual Rights section of this notice.
6. **PLAN SPONSORS:** Your health plan information, and the health plan 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 health plan information in such circumstances.
7. **UNDERWRITING:** Your health plan 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 Employer does not issue that contract, Your health plan 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).
8. **MARKETING:** Your health plan information may be used to provide information about health-related benefits, services or treatment alternatives that may be of interest to You. Your health plan information may be disclosed to a business associate assisting us in providing that information to You. We will not market products or services other than health-related products or services to You unless You affirmatively opt-in to receive information about non-health products or services We may be offering. You have the right to opt out of fundraising communications.
9. **RESEARCH:** Your health plan information may be used or disclosed for research purposes, as allowed by law.
10. **YOUR DEATH:** If You die, Your health plan information may be disclosed to a coroner, medical examiner, funeral director or organ procurement organization.
11. **AS REQUIRED BY LAW:** Your health plan information may be used or disclosed as required by state or federal law.
12. **COURT OR ADMINISTRATIVE ORDER:** Health plan information may be disclosed in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances.
13. **VICTIM OF ABUSE:** If You are reasonably believed to be a victim of abuse, neglect, domestic violence or other crimes, health plan 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. Health plan 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.

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

INDIVIDUAL RIGHTS

1. **DESIGNATED RECORD SET:** You have the right to look at or get copies of Your health plan information, with limited exceptions. You must make a written request, using a form available from the Privacy Office, to obtain access to Your health plan information. If You request copies of Your health plan information, You will be charged 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 cost of providing Your health plan information in the requested format. If You prefer, the Employer will prepare a summary or explanation of Your health plan information for a fee. For a more detailed explanation of the fee structure, please contact the Privacy Office. Employer requires advance payment before copying Your health plan information.
2. **ACCOUNTING OF DISCLOSURES:** You have the right to receive an accounting of any disclosures of Your health plan information made by the Employer or a business associate for any reason, other than treatment, payment, or health care operations purposes within the past six years. 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 health plan 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.
3. **RESTRICTION REQUESTS:** You have the right to request restrictions on the Employer's use or disclosure of Your health plan information. Employer is not required to agree to such requests. Employer will only restrict the use or disclosure of Your health plan information as set forth in a written agreement that is signed by a representative of the Privacy Office on behalf of the Employer.
4. **BREACH NOTICE:** 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.
5. **CONFIDENTIAL COMMUNICATIONS:** If You reasonably believe that sending health plan information to You in the normal manner will endanger You, You have the right to make a written request that the Employer communicate 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 the Employer. Follow up with a written request is required

as soon as possible. Employer must accommodate Your request if it: is reasonable, specifies how and where to communicate with You, and continues to permit collection of premium and payment of claims under Your health plan.

6. **AMENDMENT REQUESTS:** You have the right to make a written request that the Employer amend Your health plan information. Your request must explain why the information should be amended. Employer may deny Your request if the health plan information You seek to amend was not created by the Employer or for other reasons permitted by its legal obligations. If Your request is denied, the Employer will provide a written explanation of the denial. If You disagree, You may submit a written statement that will be included with Your health plan information. If the Employer accepts Your request, reasonable efforts will be made to inform the people that You designate about that amendment. Any future disclosures of that information will be amended.
7. **RIGHT TO REQUEST WRITTEN NOTICE:** If You receive this notice on the Employer's 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 Employer's privacy practices or have questions or concerns, please contact the Privacy Office.

If You: (1) are concerned that the Employer has violated Your privacy rights; (2) disagree with a decision made about access to Your health plan information or in response to a request You made to amend or restrict the use or disclosure of Your health plan information; or (3) request that the Employer 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. Employer will furnish the address where You can file a complaint with the U.S. Department of Health and Human Services upon request.

Employer supports Your right to protect the privacy of Your health plan information. There will be no retaliation in any way if You choose to file a complaint with the Employer or subsidiaries and affiliates, or with the U.S. Department of Health and Human Services.

The Privacy Office

City of Murfreesboro

111 West Vine Street, Murfreesboro, TN 37130, USA

Phone: 615-848-2553

Fax: 615904-6506

E-mail: prussell@murfreesborotn.gov



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