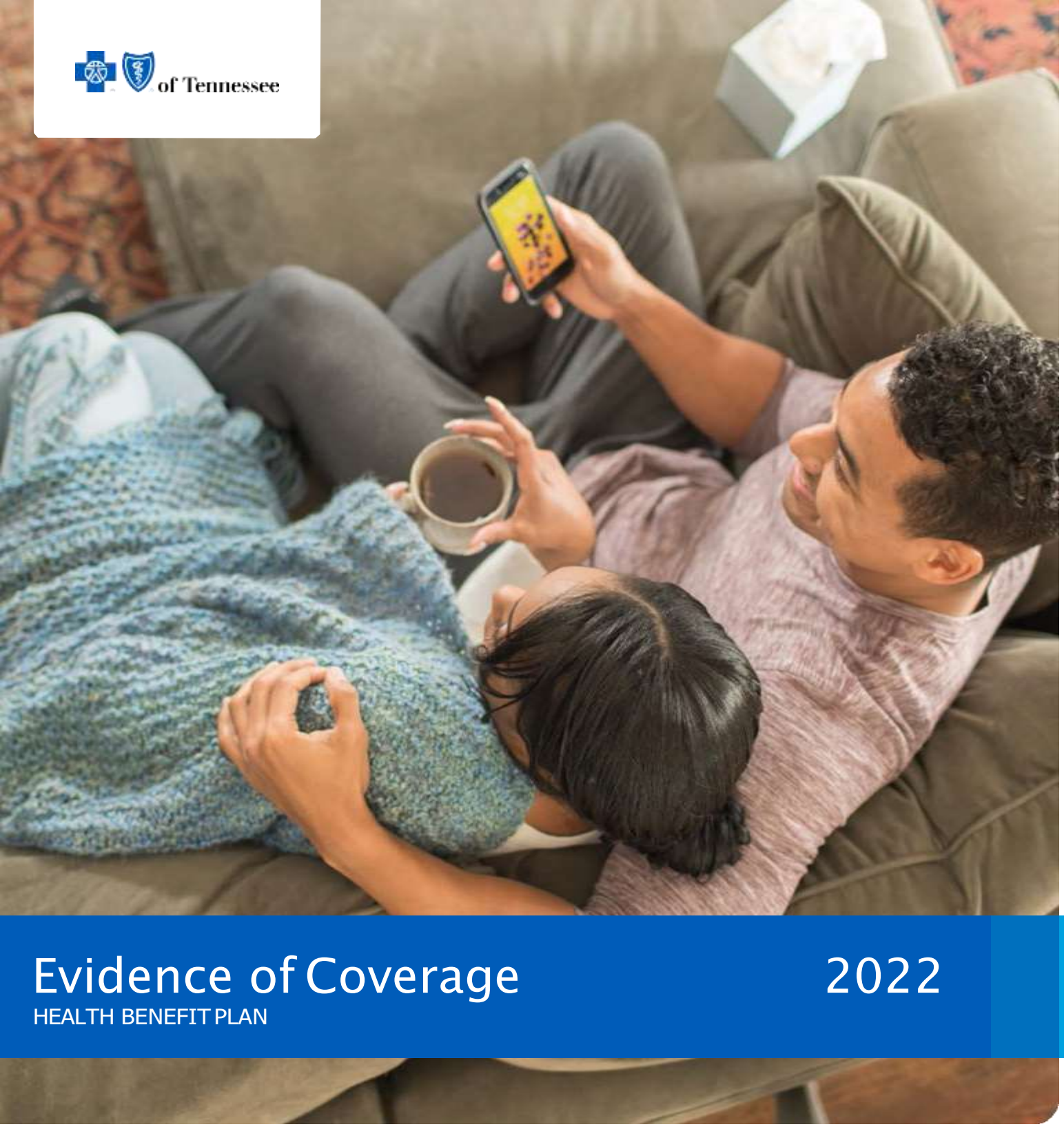

Evidence of Coverage 2022

HEALTH BENEFIT PLAN

SUMNER COUNTY EMPLOYEES INSURANCE TRUST FUND

Option 2 - 2022

COMM-662 (8/16)
Health EOC - Members

Nondiscrimination Notice

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

BlueCross:

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

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

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

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

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

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

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

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

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

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

ໂປດຊາບ: ຖ້າ ວ່າ ທ່ານ ເວົ້າ ພາສາ ລາວ, ການ ບໍ ລິ ການ ຊ່ ວຍ ເຫ ຼືອ ດ້ ານ ພາສາ, ໂດຍ ບ ່ ເສ ັ ຽ ຄ ່ າ, ແມ ນ ພ ້ ອມ ທ ີ ່ ຈ ະ ໃຫ ້ ທ ່ ານ. ໂທ 1-800-565-9140 (TTY: 1-800-848-0298).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NOTICE

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

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

NOTICE TO GO OUT TO ALL EMPLOYEES AGE 60 AND OVER

ACTIVE EMPLOYEES AND ELIGIBLE DEPENDENTS AGE 64 AND UNDER

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

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

ACTIVE EMPLOYEES AND ELIGIBLE DEPENDENTS AGE 65 AND OVER

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

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

RETIREES AND ELIGIBLE DEPENDENTS AGE 64 AND UNDER

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

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

RETIREES AND ELIGIBLE DEPENDENTS AGE 65 AND OVER

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

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

TABLE OF CONTENTS

INTRODUCTION

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

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

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

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

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

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

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

INDEPENDENT LICENSEE OF THE BLUECROSS BLUESHIELD ASSOCIATION

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

RELATIONSHIP WITH NETWORK PROVIDERS

1. Independent Contractors

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

While the administrator has the authority to make benefit and eligibility determinations and interpret the terms of Your Coverage, the Employer, as the Plan Administrator, has the discretionary authority to make the final determination regarding the terms of Your Coverage ("Coverage Decisions"). Both the administrator and the Employer make Coverage Decisions based on the terms of this EOC, the ASA, and applicable State or Federal laws.

You may request reconsideration of a Coverage Decision as explained in the Grievance Procedure section of this EOC. The Participation Agreement requires Network Providers to fully and fairly explain Coverage Decisions to You, upon request, if You decide to request that the administrator reconsider a Coverage Decision.

2. Termination of Providers' Participation

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

3. Provider Directory

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

REWARDS OR INCENTIVES

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

OUR PAYMENT METHODS FOR NETWORK PROVIDERS

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

NOTIFICATION OF CHANGE IN STATUS

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

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

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

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

SCHEDULE OF BENEFITS -
Sumner County Employees Insurance Trust Fund

Group Number: 88230

Benefits Effective: July 1, 2022

Benefits Available

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

Calculation of Coinsurance

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

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

Member's Responsibility

Prior Authorization may be required for certain services. Please have Your Physician contact BlueCross at the telephone number shown on Your identification card before services are provided. Otherwise, Your benefits may be reduced or denied.

A Clinical Trial is a prospective biomedical or behavioral research study of human subjects that is designed to answer specific questions about biomedical or behavioral interventions (vaccines, drugs, treatments, devices, or new ways of using known drugs, treatments, or devices). Clinical Trials are used to determine whether new biomedical or behavioral interventions are safe, efficacious, and effective. **Only routine patient care associated with a Clinical Trial (but not the Clinical Trial itself) will be Covered under the Plan's benefits in accordance with Utilization Policies.**

The Dependent Child Limiting Age will be to age 26. (Dependent coverage will end on the last day of the month following Your 26th birthday.)

DEDUCTIBLE

Deductible to be applied to:	Network Provider	Out-of-Network Provider
All Covered Services (unless otherwise specified)	$1,125	$1,725
Family Deductible Maximum	$3,375	$5,175

COINSURANCE:

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

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

Some procedures require Prior Authorization. Call Our consumer advisors to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, benefits may be reduced to 50% for Out-of-Network Providers and 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.

Coinsurance to be applied to:	Network Provider	Out-of-Network Provider
All Facility Covered Services after Deductible has been satisfied (unless otherwise specified)	70%	50%
Professional Provider Covered Services***** after Deductible has been satisfied (unless otherwise specified)	70%	50%
Inpatient and Outpatient Hospital Services	70% after Deductible	70% of the Maximum Allowable Charge Deductible
***Professional Provider Covered Services include all Covered Services provided at the Provider's office for routine Office Visits and/or Consultations (if Consultations are not considered on the same basis as a routine Office Visit).**		
Emergency Room Services*	70%, subject to the Deductible and a $250 Copayment	70%, subject to the Deductible and a $250 Copayment
***The $250 Copayment is waived if admitted to the Hospital as a bed patient and will not apply to any other Deductible or Out-of-Pocket Maximum.**		
Ground Ambulance	70% of the Billed Charges after Deductible	70% of the Billed Charges after Deductible
Air Ambulance	70% after Deductible	70% of the Billed Charges after Deductible
Ambulance Accident	70%	70% of the Maximum Allowable Charge
All Other Covered Services after Deductible has been satisfied (unless otherwise specified)	70%	50%

Preventive Services Physical Exams (6 years and older) Routine Pap Smear, and Prostate Exam	100% 100%	**Preventive Services are not available**
Mammograms (including 3D Mammograms)	100%	**Preventive Services are not available**
Electric Breast Pump with a maximum of $120 Limited to 1 Breast Pump per pregnancy	100%	**Preventive Services are not available**
Hearing Aids (for anyone age 19 and over) Limited to $6,000 every 5 years including earmolds and services to select, fit and adjust the hearing aids (as determined by Your Annual Benefit Period)	70%	50%
Hearing Aids for Members under age 18 Limited to one per ear every 3 years including earmolds and services to select, fit and adjust the hearing aids (as determined by Your Annual Benefit Period)	70%	50%
Coinsurance percentages will be applied to the lesser of the negotiated fee or other basis for our reimbursement of Covered Services.		

OUT-OF-POCKET MAXIMUM:

Maximum to be applied to:	Network Provider	Out-of-Network Provider
Individual	$6,850	unlimited
Family	$13,700	unlimited

Organ Transplant Services			
Transplant Services	**Blue Distinction Centers for Transplants (BDCT) Network**: 70% after Network Deductible, Network Out-of-Pocket Maximum applies.	**Transplant Network:** 70% after Network Deductible, Network Out-of-pocket Maximum applies.	**Out-of-Network Providers**: 50% after Out-of-Network Deductible, Out-of-Network Out-of-Pocket Maximum applies.
Network Providers not in our Transplant Network include Network Providers in Tennessee and BlueCard PPO Providers outside Tennessee.			

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

ADDITIONAL BENEFITS

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

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

SPECIAL PROVISIONS

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

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

PRESCRIPTION DRUG PROGRAM

	Prescription Drugs for Retail Network and Home Delivery Network				
Prescription Drugs	**Preferred Generic Drug**	**Non-Preferred Generic Drug**	**Preferred Brand Drug**	**Non-Preferred Brand Drug**	**Out-of-Network**
RX04 Retail Network – Up to a 34 day supply	10% with a max of $60 Or actual cost of drug, whichever is less	10% with a max of $60 Or actual cost of drug, whichever is less	25% with a max of $140 Or actual cost of drug, whichever is less	35% with a max of $240 Or actual cost of drug, whichever is less	You pay all costs, then file a claim for reimbursement
RX04 Retail Network - Greater than a 34 day supply	Not Covered; must utilize either **Home Delivery Network or Plus90 Retail Network**				
Home Delivery Network and Plus90 Retail Network – Up to a 34 day supply	10% with a max of $60 Or actual cost of drug, whichever is less	10% with a max of $60 Or actual cost of drug, whichever is less	25% with a max of $140 Or actual cost of drug, whichever is less	35% with a max of $240 Or actual cost of drug, whichever is less	You pay all costs, then file a claim for reimbursement
Home Delivery Network and Plus90 Retail Network – For a 35 to 68 day supply	10% with a max of $120 Or actual cost of drug, whichever is less	10% with a max of $120 Or actual cost of drug, whichever is less	25% with a max of $280 Or actual cost of drug, whichever is less	10% with a max of $480 Or actual cost of drug, whichever is less	You pay all costs, then file a claim for reimbursement
Home Delivery Network and Plus90 Retail Network – For a 69 to 90 day supply	10% with a max of $180 Or actual cost of drug, whichever is less	10% with a max of $180 Or actual cost of drug, whichever is less	10% with a max of $420 Or actual cost of drug, whichever is less	10% with a max of $720 Or actual cost of drug, whichever is less	You pay all costs, then file a claim for reimbursement

Self-Administered Specialty Drugs - To receive benefits for self-administered Specialty Drugs, You must use a Preferred Pharmacy in Our Specialty Pharmacy Network.

Self-administered Specialty Drugs are limited up to a 30 day supply per Prescription.

Self-administered Specialty Drugs	**Generic Drug**	**Preferred Brand Drug**	**Non-Preferred Brand Drug**	**Out-of-Network**
Preferred Specialty Pharmacy Network	$60 Copay	$140 Copay	$240 Copay	Not Covered

Additional Provisions

90-102 day supplies are available through the Home Delivery Network and the Plus90 Retail Network. See bcbst.com to locate network pharmacies and to learn more about the Home Delivery Network.

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

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

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

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

1. Covered Services

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

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

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

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

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

   – listed on the Drug Formulary.

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

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

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

f. Medically Necessary Prescription Drugs used during chemical dependency treatment.

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

h. Certain drugs require Step Therapy. When Step Therapy is required, You must initially try a drug that has been proven effective for most people with Your condition. However, if You have already tried an alternate, less expensive drug and it did not work, or if Your doctor believes that You must take the more expensive drug because of Your medical condition, Your doctor can contact the administrator to request an exception. If the request is approved, the administrator will Cover the requested drug.

i. Compound Drugs, with the exception of bulk powders, chemicals and kits, are only Covered when filled at a Network Pharmacy. The Network Pharmacy must submit the claim through the Administrator's pharmacy benefit manager. The claim must contain a valid national drug code (NDC) number for at least one ingredient in the Compound Drug.

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

k. If You abuse or over use pharmacy services outside of Our administrative procedures, We may restrict Your Pharmacy access. We will work with You to select a Network Pharmacy, and You can request a change in Your Network Pharmacy.

2. Exclusions

a. Prescription Drugs not on the Drug Formulary;

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

c. any Prescription Drugs which exceed Quantity Limits specified by the Plan's P & T Committee;

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

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

f. medications intended to terminate a pregnancy;

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

h. artificial appliances;

i. allergen extracts;

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

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

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

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

n. Prescription Drugs used for the treatment of infertility;

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

p. all newly FDA approved drugs prior to review by the Administrator's P & T Committee. Prescription Drugs that represent an advance over available therapy according to the P & T Committee will be reviewed within at least six (6) months after FDA approval.

Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug, will be reviewed within at least twelve (12) months after FDA approval;

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

r. FDA approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia;

s. Experimental and/or Investigational Drugs;

t. Prescription Drugs or refills dispensed:

- in quantities in excess of amounts specified in the Benefit payment section;
- without Our Prior Authorization when required; or
- which exceed any applicable Annual Maximum Benefit, or any other maximum benefit amounts stated in the EOC.

u. Prescription and non-Prescription medical supplies, devices and appliances are not Covered, except for syringes used in conjunction with injectable medications or other supplies used in the treatment of diabetes and/or asthma.

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

w. Immunological agents, including but not limited to: (1) biological sera, (2) blood, (3) blood plasma; or (4) other blood products are not Covered, except for blood products required by hemophiliacs.

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

y. any Prescription Drugs or medications used for the treatment of sexual dysfunction, including but not limited to erectile dysfunction (e.g. Viagra), delayed ejaculation, anorgasmia and decreased libido. This exclusion does not apply to office visits.

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

3. <u>Specialty Drugs</u>

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

1. Covered Services

a) Provider-administered Specialty Drugs as identified on the Provider-administered Specialty Drug list. The current list can be found at bcbst.com or by calling the number on the back of Your ID card.

b) Self-administered Specialty Drugs as identified on the Drug Formulary when dispensed by a Pharmacy in Our Specialty Pharmacy Network. The Drug Formulary can be found at bcbst.com or by calling the number on the back of Your ID card.

2. Exclusions

   a) Self-administered Specialty Drugs that are not dispensed by a Pharmacy in Our Specialty Pharmacy Network.

   b) FDA-approved drugs used for purposes other than those approved by the FDA, unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia.

4. DEFINITIONS

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

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

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

4. **Drug Copayment** - The dollar amount specified herein that You must pay directly to the Network Pharmacy when the covered Prescription Drug is dispensed. The Drug Copayment is determined by the type of drug purchased, and must be paid for each Prescription Drug.

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

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

7. **Generic Drug** -- A Prescription Drug that has the same active ingredients, strength or concentration, dosage form and route of administration as a Brand Name Drug. The FDA approves each Generic Drug as safe and effective as a specific Brand Name Drug. Generic Drugs may be available as preferred Generic Drugs and non-preferred Generic Drugs and are identified on the Drug Formulary, which can be found at bcbst.com or by calling the Member Service number on the back of Your ID card.

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

9. **Network Pharmacy** - a Pharmacy that has entered into a Network Pharmacy Agreement with the administrator or its agent to legally dispense Prescription Drugs to You, either in person or through home delivery.

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

11. **Out-of-Network Pharmacy** - a Pharmacy that has not entered into a service agreement with the administrator or its agent to provide benefits at specified rates to You.

12. **Pharmacy/Pharmacies** - a state or federally licensed establishment which is physically separate and apart from the office of a Practitioner, and where Prescription Drugs are

dispensed by a pharmacist licensed to dispense such drugs under the laws of the state in which he or she practices.

13. **Pharmacy and Therapeutics Committee or P&T Committee -** A panel of the Administrator's participating pharmacists, Network Providers, medical directors and pharmacy directors which reviews medications for safety, efficacy and cost effectiveness. The P&T Committee evaluates medications for addition and deletion from the: (1) Drug Formulary; (2) Preferred Brand Drug list; (3) Prior Authorization Drug list; and (5) Quantity Limitation list. The P&T Committee may also set dispensing limits on medications.

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

15. **Preferred Brand Drug -** Brand Name Drugs that the Administrator has reviewed for clinical appropriateness, safety, therapeutic efficacy, and cost effectiveness. The Preferred Brand Drug list is reviewed at least annually by the P&T Committee.

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

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

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

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

20. **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 in this EOC. Self-administered Specialty Drugs may be available as a Generic Drug, Preferred Brand Drug or Non-Preferred Brand Drug and are identified on the Drug Formulary, which can be found at bcbst.com or by calling the Member Service number on the back of Your ID card.

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

22. **Step Therapy** – A form of Prior Authorization that begins drug therapy for a medical condition with the most cost-effective and safest drug therapy and progresses to alternate drugs only if necessary. Prescription drugs subject to Step Therapy guidelines are: (1) used only for patients with certain conditions; (2) Covered only for patients who have failed to respond to, or have demonstrated an intolerance to, alternate Prescription Drugs, as supported by appropriate medical documentation; and (3) when used in conjunction with selected Prescription Drugs for the treatment of Your condition.

SECTION I - ELIGIBILITY

COVERAGE FOR YOU

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

COVERAGE FOR YOUR DEPENDENTS

If You are covered by this program, You may enroll Your Eligible Dependents. Your covered Dependents are also called Members. The names of Dependents for whom application for coverage is made must be listed on the application on file in our records. Subsequent applications for Dependents must be submitted to BlueCross in writing.

TYPES OF COVERAGE AVAILABLE

Individual - Employee only

Two-Person - Employee and one Eligible Dependent

Family - Employee and all eligible Dependents

ELIGIBLE EMPLOYEES

To be eligible for coverage an Employee must:

- any employee who works an average of at least 30 hours per week for more than 120 days in a year, or
- be an eligible Dependent of Employees; or
- be an Employee who was covered by insurance through one of the various Employers at the inception of the Trust; or
- be an Employee, who at the inception of employment was covered by insurance, but who has his/her weekly work hours cut to less than that eligible by law due to lack of funds in a particular department.

ELIGIBLE EARLY RETIREES AND DISABLED EMPLOYEES – COUNTY GENERAL AND HIGHWAY DEPARTMENT-RETIREE COVERAGE WILL BE DISCONTINUED AND EMPLOYEES HIRED JANUARY 1, 2020 OR AFTER WILL NOT BE OFFERED THIS BENEFIT.

Anyone hired on or after January 1, 2020, will not be eligible to participate in the county's retiree insurance program.

Effective July 18, 2022, any sick time any employee has credited towards retirement credits with the Tennessee Consolidated Retirement System will also be counted toward the years of service for the retiree insurance program.

To be eligible for coverage as an early retiree or as a disabled employee, an employee must meet the eligibility criteria as shown below. Sumner County will pay 75% of the cost of medical insurance premiums for an eligible employee at retirement if the employee meets the following qualifications.

• The eligible employee must be at least 60 years of age and have 20 years or more of service with Tennessee Consolidated Retirement System (TCRS) with the last 10 years being with Sumner County Government; or

• The eligible employee, of any age, obtains 30 years of TCRS credits with the last 10 years being with Sumner County Government; and

• An employee must have the county insurance for the last five years of their employment with Sumner County and meet all other requirements in order to obtain the retiree insurance.

• Only those that turned in their TCRS credits by Nov 1, 2020 are eligible to use the other entities toward their retirement.

• A disabled employee must be certified as disabled by the Social Security Administration, must have been enrolled in the county insurance program at the time of disability and must have 10 or more years of county service at the time of disability to be eligible.

The employee will be responsible for 25% of the cost of this coverage.

If an employee is eligible for retiree insurance and a dependent participates in the plan for at least the last five-year period, the dependent can retain coverage as part of the retiree's plan; however, the employee must pay 100% of the cost for dependents.

If an employee and spouse are both employed by Sumner County Government and meet all other requirements, they have

the option of two individual policies at 25% of the total cost of the coverage.

The employee and dependents must elect the retiree insurance at the time of the employee's retirement from Sumner County. If they elect to drop the retiree insurance, they are no longer eligible and cannot reobtain that insurance.

Programs to share in the cost for the retired employee's coverage are the responsibility of the county group offering the program and not the insurance trust.

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

For retiree insurance only, years of service with Sumner County Board of Education will count toward total years of service with Sumner County Government.

EFFECTIVE DATE

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

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

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

APPLYING FOR COVERAGE

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

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

a. The Subscriber's current legal spouse who meets all requirements of a valid marriage contract in the state of residence, but will not include a domestic partner; or

b. The natural, legally adopted, foster or step-child(ren) of the Subscriber or the Subscriber's spouse who is under the age limit stated on the Schedule of Benefits and is dependent upon Subscriber or Subscriber's spouse for at least 50% of his or her support. In addition, Eligible Dependents shall include children placed with the Subscriber or the Subscriber's spouse pending adoption and children for whom the Subscriber or Subscriber's spouse is court-appointed legal guardian; or

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

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

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

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

CHANGING COVERAGE

If Your marital status changes (marriage or divorce) or if there is a change in the number of Your children (birth, adoption), You may

want to change Your coverage to one of the other options available.

When You need to make a change, You should (1) tell Your employer, and (2) apply for any needed change within 30 days of the change in family status, date the new Dependent is acquired, etc.

A newborn child of the Subscriber or Subscriber's spouse is a Covered Dependent from the moment of birth. The Subscriber must enroll that child within 30 days of the date of birth. If the Subscriber fails to do so, and an additional Payment is required to cover that child, the Plan will not provide Coverage for that child after 30 days from the child's date of birth.

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

If You Did Not Enroll On Time

If You wait more than 30 days from the date You are first eligible to apply or add a Dependent You and or the Dependent will be considered a Late Enrollee. If a change in premium is unnecessary, Coverage for You or the Dependent will be effective on the next billing date following our receipt of the application for Coverage. If a change in premium is necessary, a change cannot be made for this event until the next open enrollment.

However, a person will <u>not</u> be considered a Late Enrollee if:

- he or she already had other health care coverage at the time coverage under this plan was previously offered; and
- he or she stated in writing at that time that such other coverage was the reason for declining coverage under this plan; and
- such other coverage is:

(1) COBRA and the COBRA coverage is exhausted; or

(2) Non-COBRA and

(a) You lose eligibility under the other coverage (other than for a failure to pay premiums); or

(b) Employer contributions for the other coverage ended; and

- he or she applies for coverage under this plan within 30 days after the loss of the other coverage.

Dependents who become eligible for coverage under this plan by reason of marriage, birth, adoption or placement for adoption after the Subscriber's Effective Date will not be considered Late Enrollees, provided application is made by the Subscriber on behalf of such person(s) within 30 days of the marriage, birth, adoption or placement for adoption.

Enrollment upon Change in Status

An Employee may be eligible to change his or her Coverage other than during the Open Enrollment Period when he or she has a change in status event. The Employee must request the change within 30 days of the change in status. Any change in the Subscriber's elections must be consistent with the change in status.

To notify the Plan of a change in status event, the Subscriber must submit a change form to the Group representative within 30 days from the date of the event causing that change of status. Such events may include, but are not limited to: (1) marriage or divorce; (2) death of the Subscriber's spouse or dependent; (3) dependency status; (4) Medicare eligibility; (5) coverage by another Payor; (6) birth or adoption of a child; (7) termination of employment, or commencement of employment, of the Subscriber's spouse; (8) switching from part-time to full-time, or from full-time to part-time status by the Subscriber or the Subscriber's spouse; (9) the Subscriber or the Subscriber's spouse taking an unpaid leave of absence, or returning from unpaid leave of absence; (10) significant change in the health coverage of the Subscriber's or the Subscriber's spouse attributable to the spouse's employment.

ANNUAL OPEN ENROLLMENT

An Open Enrollment Period is established for a one-month period each year whereby Employees can elect coverage without furnishing proof of insurability.

SECTION II - INTER-PLAN ARRANGEMENTS

1. Out-of-Area Services

Overview

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

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

Inter-Plan Arrangements Eligibility – Claim Types

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

A. BlueCard® Program

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

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

e. The billed charges for Covered Services; or

f. The negotiated price that the Host Blue makes available to Us.

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

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

B. Special Cases: Value-Based Programs

- *BlueCard® Program*

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

- *Value-Based Program Definitions*

  Accountable Care Organization (ACO): A group of healthcare providers who agree to deliver

coordinated care and meet performance benchmarks for quality and affordability in order to manage the total cost of care for their member populations.

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

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

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

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

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

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

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

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

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

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

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

D. Nonparticipating Providers Outside Our Service Area

1. **Member Liability Calculation**

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

law, as applicable, will govern payments for out-of-network emergency services.

2. **Exceptions**

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

E. Blue Cross Blue Shield Global® Core

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

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

- **Inpatient Services**

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

- **Outpatient Services**

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

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

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

SECTION III - PRIOR AUTHORIZATION, CARE MANAGEMENT, MEDICAL POLICY AND PATIENT SAFETY

BlueCross BlueShield of Tennessee provides services to help manage Your care including, performing Prior Authorization of certain services to ensure they are Medically Necessary, Concurrent Review of hospitalization, discharge planning, Care Management and specialty programs, such as transplant case management. BlueCross also provides Utilization Policies.

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

A. Prior Authorization

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

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

- Inpatient Hospital and Inpatient Hospice stays (except initial maternity admission and Emergency admissions)
- Skilled nursing facility and rehabilitation facility admissions
- Certain outpatient Surgeries and/or procedures
- Certain air ambulance services
- Certain Specialty Drugs
- Certain Prescription Drugs (if Covered by a prescription drug card)
- Certain Advanced Radiological Imaging services
- Certain Durable Medical Equipment (DME)
- Certain prosthetics
- Certain orthotics

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

Contact Employer for gastric bypass Prior Authorization requirements, and to obtain the appropriate Prior Authorization forms.

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

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

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

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

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

B. Care Management

A number of Care Management programs are available to You across the care spectrum, including those with low-risk health conditions and/or complicated medical needs.

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

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

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

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

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

C. Medical Policy

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

Medical policies state whether or not a technology is Medically Necessary, Investigational or cosmetic. As technologies change and improve, and as Members' needs change, We may reevaluate and change medical policies without formal notice. Visit bcbst.com/mpm to review Our medical policies.

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

D. Patient Safety

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

HEALTH AND WELLNESS SERVICES

BlueCross provides You with resources to help improve and manage Your health. To learn more about these resources, log in at bcbst.com or call the number on the back of Your ID card.

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

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

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

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

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

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

SECTION IV - YOUR BENEFITS

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

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

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

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

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

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

HOSPITAL AND OTHER FACILITY PROVIDER SERVICES

Inpatient Services-(includes inpatient Hospice)

Room, board, and general nursing care in a:

- room and board; general nursing care; medications, injections, diagnostic services,
- Special Care Unit as approved by BlueCross;
- Use of operating, delivery and treatment rooms;
- Drugs and medicines, including take home drugs;
- Sterile dressings, casts, splints and crutches;
- Anesthetics;
- Diagnostic services (x-ray and laboratory and certain other tests); and
- Certain therapy services.

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

Outpatient Services

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

Emergency Services

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

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

An observation stay and/or Surgery that occurs in conjunction with an ER visit may be subject to Member cost share under the Schedule of Benefits in addition to Member cost share for the ER visit.

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES

Surgery

Operative and cutting procedures.

Multiple or Bilateral Surgical Procedures

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

- the amount of benefits for the procedure for which the highest dollar amount would be billed (if charges for the surgical procedures are different); and
- up to one-half of the benefits which are available with respect to the other covered surgical procedure(s), whether performed through the same or separate incisions.

Assistant Surgeon

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

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

Anesthesia

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

Physicians' Services

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

  Preventive Health Exam and related services for adults and children in accordance with federal regulations, as outlined below and performed by the physician during the Preventive Health Exam or referred by the physician as appropriate, including:

  1. Screenings and counseling services with an A or B recommendation by the United States Preventive Services Task Force (USPSTF)

  2. Bright Futures recommendations for infants, children and adolescents supported by the Health Resources and Services Administration (HRSA)

  3. Preventive care and screening for women as provided in the guidelines supported by HRSA, and

  4. Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC).

Diagnostic Services

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

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

Maternity Services

Pregnancy and childbirth are covered on the same basis as an illness. Unless the mother and attending health care provider agree on an earlier date of discharge, benefits will be

available for Hospital stays of not less than 48 hours following a conventional delivery or 96 hours following a cesarean delivery.

OTHER SERVICES

Allergy Testing

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

Ambulance

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

- Ambulance Services - Air
    1. Medically Necessary and Medically Appropriate air transportation from the scene of an accident or Emergency resulting in complex trauma, high risk injuries, or life-threatening medical emergencies to the nearest hospital with adequate facilities for evaluation and initial management. Air transportation is Covered only when Your condition requires immediate and rapid transport that cannot be provided by ground transport.
    2. Air transportation for inter-facility transfers when Medically Necessary treatment, services, or care are not available at the sending facility. The transfer must be to the nearest appropriate facility that is able to provide Medically Necessary care. Air transportation is Covered only when Your condition requires transport that cannot be provided by ground transport.
- Ambulance Services - Ground
    1. Medically Necessary and Medically Appropriate ground transportation from the scene of an accident or Emergency to the nearest hospital with adequate facilities for evaluation and initial management.
    2. Medically Necessary and Medically Appropriate treatment at the scene (paramedic services) without ambulance transportation.
    3. Medically Necessary and Medically Appropriate ground transport when Your condition requires basic or advanced life support, or safe transportation to site of service for the necessary level of care in the absence of appropriate alternatives.

- Exclusions
    1. Transportation for the convenience of You or reasons other than Medically Necessary treatment and care for You, such as the needs or convenience of, Your family and/or Your physician or other Provider.
    2. Transportation that is not essential to reduce the probability of harm to You.
    3. Transportation for specific Provider or facility continuity of care when there are closer facilities able to provide the same services and level of care.

Cardiac Rehabilitation Services

Subject to Pre-Treatment Certification Requirements, benefits will be available as stated in the Schedule of Benefits for one Cardiac Rehabilitation Services within a 12-month period. Covered Services include Rehabilitation Services designed primarily to improve functional capacity limited to 36 visits.

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

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

Services must be rendered in a Cardiac Rehabilitation Center recognized by the American Association of Cardiovascular and Pulmonary Rehabilitation in accordance with BlueCross Medical Necessity guidelines with regard to the frequency and duration of exercise and education programs.

Dental Services

Medically Necessary and Medically 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 head and neck cancer, or to treat accidental injury to the jaw, sound natural teeth, mouth, or face, due to external trauma. The Surgery and services to treat accidental injury must be started within 3 months and completed within 12 months of the accident.

   b) For dental services not listed in subsection a. above, general anesthesia, nursing and related hospital expenses in connection with an inpatient or outpatient dental procedure are Covered, only when one of the conditions listed below is met.

Prior Authorization for inpatient services is required.

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 health disorders 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.

   c) Oral Appliances to treat obstructive sleep apnea, if Medically Necessary.

2. Exclusions

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

   b) Treatment for correction of underbite, overbite, and misalignment of the teeth, including, but not limited to, braces for dental indications, and occlusal splints and occlusal appliances to treat malocclusion/misalignment of teeth. This exclusion does not apply to Medically Necessary orthognathic Surgery.

   c) Extraction of impacted teeth, including wisdom teeth.

Temporomandibular Joint Dysfunction (TMJ)

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

- Covered Services

  a) Diagnosis and treatment of TMJ or TMD, including, but not limited to, diagnostic study casts and Oral Appliances to stabilize the jaw joint.

- 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. This exclusion does not apply to Medically Necessary orthognathic Surgery.

Durable Medical Equipment and Supplies

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

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

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

Eyeglasses or Contact Lenses

- one set following cataract Surgery required to adjust for vision changes due to cataract Surgery and obtained within 6 months following the Surgery
- One (1) retinopathy screening for diabetics per Annual Benefit Period

Hearing Aids

Medically Necessary and Medically Appropriate Hearing Aids used to enhance hearing when sustained loss is due to (1) birth defect; (2) accident; (3) illness; or (4) Surgery. Cochlear implants are not considered Hearing Aids; see the "Prosthetics/Orthotics" section for benefits.

- Covered Services
  a. The initial purchase of Covered Hearing Aids, limited as indicated in Schedule of Benefits.
  The repair, adjustment or replacement of components and accessories necessary for the effective functioning of Covered equipment, except as otherwise indicated under Exclusions.
- Exclusions
  a. Hearing Aid batteries, cords and other assistive listening devices such as FM systems.

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

Home Health Care

Benefits are available for the following services when prescribed by the Member's Physician and performed and billed by a Home Health Care Agency: part-time or intermittent nursing care by a visiting RN or LPN; physical therapy and respiratory therapy by persons licensed to perform such services; oxygen and its administration; and diagnostic services.

Hospice Home Care-Outpatient

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

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

In-home services are available, such as:

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

Mammography Screening

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

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

Obstetrical and Gynecological Exam

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

Office Visits for an Illness or Injury

Organ Transplants

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

- Prior Authorization

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

- Benefits

  Transplant benefits are different than benefits for other services.

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

  You have access to three levels of benefits:

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

  b. **Transplant Network:** If You want to receive the maximum benefit, You should use a facility in the BDCT Network. If You instead have a transplant performed at a facility in the Transplant Network (non-BDCT), the Administrator will pay at the benefit level listed in the Schedule of Benefits for the Transplant Network. **Not all Network Providers are in the Transplant Network. Please check with the Transplant Case Management department to determine if the Transplant Network is the best network available for Your specific transplant type.**

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

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

- Covered Services

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

  - Pancreas
  - Pancreas/Kidney
  - Kidney
  - Liver
  - Heart

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

Benefits may be available for other organ transplant procedures that are not Investigational and that are Medically Necessary and Medically Appropriate.

- Organ and Tissue Procurement

  Organ and tissue acquisition/procurement are Covered Services, subject to the benefit level listed in the Schedule of Benefits and limited to the services directly related to the Transplant itself:

  - Donor Search
  - Testing for donor's compatibility
  - Removal of the organ/tissue from the donor's body
  - Preservation of the organ/tissue
  - Transportation of the tissue/organ to the site of transplant
  - Donor follow up care directly related to the organ donation, except as otherwise indicated under Exclusions

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

- Travel Expenses for Transplant Recipients

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

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

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

  - Meals and lodging expenses are Covered up to $150 per day, subject to the following:
    - Lodging expenses are limited to $50 per person day.
    - Meals are only Covered when provided at the facility where You are receiving inpatient medical care.
    - The aggregate limit for travel expenses, including meals and lodging, is $10,000 per Covered transplant.

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

- Travel Expenses for Live Kidney Donors

  Travel expenses are available to help offset the costs a donor may incur when donating a kidney to Our Member, subject to the limits stated below.

  Covered travel expenses must be approved by the Transplant Case Management department and include travel to and from the transplant facility for the kidney donation procedure and required pre-testing and post-donation follow-up care. Covered travel expenses will not apply to the Deductible or Out-of-Pocket Maximum if donor is a Member.

  - Meals and lodging expenses are Covered up to $150 per day, subject to the following:
    - Lodging expenses are limited to $50 per person per day.
    - Meals are only Covered when provided at the facility where You are receiving inpatient medical care.
    - The aggregate limit for travel expenses, including meals and lodging, is $10,000 per kidney donation.

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

- Exclusions

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

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

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

  c. Non-Covered Services;

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

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

  f. Payment to an organ donor or the donor's family as compensation for an organ, or payment required to obtain written consent to donate an organ;

  g. Removal of an organ from a Member for purposes of transplantation into another person, except as Covered by the Donor Organ Procurement provision as described above;

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

  i. Other non-organ transplants (e.g., cornea) are not Covered under this Section, but may be Covered as an Inpatient Hospital Service or Outpatient Facility Service, if Medically Necessary

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

Inpatient and Outpatient Private Duty Nursing

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

Preventive Services

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

Child Health Supervision Services.

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

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

Physical Examination.

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

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

- Lipid Profile:
- total blood cholesterol, HDL, LDL and triglycerides

- Blood Sugar
- Hematocrit (blood count)
- Urinalysis
- Resting Electrocardiogram
- Stool for occult blood.

Prosthetic Appliances

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

Therapy Services

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

Limits do not apply to services for treatment of autism spectrum disorders.

Urgent Care Center Services

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

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

  Rehabilitative therapies in excess of the terms of the Schedule of Benefits section.

SECTION V - LIMITATIONS/EXCLUSIONS

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

EXCLUSIONS

1. services or supplies not prescribed or performed by a Physician or Professional Other Provider, as defined in the Basic Terms Section
2. services or supplies which we determine are not Medically Necessary
3. services provided before the Member's coverage begins
4. a drug, device, or medical treatment or procedure which is Experimental or Investigational (see Section VIII, Definition of Terms)
5. any work related illness or injury (unless resulting from self-employment not subject to Workers Compensation insurance requirements)
6. services or supplies furnished without cost under the laws of any government except Medicaid (TennCare[SM]) coverage provided by the State of Tennessee
7. illness or injury resulting from war occurring after the Member's coverage begins
8. services for which the patient is not required or legally obligated to pay
9. services or supplies received in a dental or medical department maintained by or on behalf of an Employer, mutual benefit association, labor union, trust, or similar group
10. services, supplies or prosthetics primarily to improve appearance or which are provided in order to correct or repair the results of a prior surgical procedure the primary purpose of which was to improve appearance

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

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

    - disease;
    - birth defect;
    - Surgery (excluding non-functional scar revision); or
    - Accidental Injury.
11. voice modification Surgery or voice therapy
12. transportation, meals, lodging, or similar expenses
13. self-treatment or services provided by any person related to the Member by blood or marriage, including the Member's spouse, parent, child, legal guardian, aunt, uncle, stepchild, or any person who resides in the Member's immediate household
14. services rendered by other than a Hospital, Physician or Other Provider(s) specified in this Plan
15. services paid under any other group, blanket or franchise insurance coverage; any other Blue Cross or Blue Shield group ASA, other health insurance plan, union welfare plan, or labor-management trust plan
16. personal hygiene and convenience items (such as air conditioners, humidifiers, or physical fitness equipment)
17. Hospital admissions which are primarily for diagnostic studies
18. whole blood, blood components, and blood derivatives which are not officially classified as drugs
19. Custodial Care
20. routine foot care, or the treatment of flat feet, corns, bunions, calluses, toe nails,

fallen arches, weak feet, and chronic footstrain

21. routine physical examinations, immunizations, and screening examinations including x-rays made without film, except as otherwise specified
22. Physician's charges for well-baby care, except as otherwise specified
23. services or supplies for dental care, except as specified
24. eyeglasses, contact lenses, and examinations for and the fitting of eyeglasses and contact lenses, except as otherwise specified.
25. Hospital admissions primarily for physical therapy

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

    (If we determine that services during a continuous Hospital confinement have developed into primarily rehabilitative services, that portion of the stay beginning on the day of such development shall not be covered under this Plan.)
27. procedures, drugs or biologicals for, or in connection with, artificial insemination, in vitro fertilization, or any other service or supply intended to create a pregnancy

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

    - treatment to correct a previous tubal pregnancy, and
    - treatment by ovulatory drugs (such as clomid) or hormonal treatment used primarily to treat irregular menstrual periods.
28. services covered under Medicare, except as required by applicable state or federal law
29. non-medical self-care or self-help training and any related diagnostic testing or medical social services
30. any services or supplies designed to correct refractive errors of the eyes, except Surgery for removal of cataracts (including surgical implant of a prosthetic lens following cataract extraction)
31. an artificial heart or any other artificial organ, or any associated expense
32. services or supplies for the reversal of sterilization
33. services or supplies incurred after a Concurrent Review determines the services and supplies are no longer Medically Necessary
34. charges in excess of the Maximum Allowable Charge for a service or supply
35. services rendered for or in connection with physical therapy which consist primarily in the application, supervision, or direction in the use of exercise or physical fitness equipment--whether or not such services are rendered by an Eligible Provider
36. any balance of charges, Deductibles, or Coinsurance resulting from a Member's failure to comply with applicable requirements of any other individual or group contract, including: Prior Authorization, second surgical opinion consultation, Outpatient Surgery, or concurrent care review programs
37. services or supplies for Inpatient treatment of bulimia, anorexia, or other eating disorders which consist primarily of behavior modification, diet and weight monitoring, and educational services
38. any charges for services and supplies rendered to a Member which require the Approval of BlueCross BlueShield of Tennessee, where such Approval is not given
39. services or supplies rendered prior to the Effective Date or after a Member's coverage is terminated, except as otherwise specified
40. room, board, and general nursing care rendered on the date of discharge, unless

both admission and discharge occur on the same day

41. a second or third surgical opinion rendered by a Physician in the same medical group or practice as (a) the Physician who initially recommended the Surgery, or (b) the Physician who rendered either the second or third surgical opinion

42. staff consultations required by Hospital rules

43. prosthetic appliances or items of Durable Medical Equipment to replace those which were lost, damaged, or stolen or prescribed as a result of improved technology

44. exercise or athletic equipment, saunas, whirlpools, air conditioners, water purifiers, humidifiers, home modifications or improvements, motorized vehicles (except electric wheelchairs), swimming pools, tanning beds, and recreational equipment

45. dental appliances, including those used for correction of jaw malformations, except where prescribed as part of a surgical procedure necessary to restore a major bodily function

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

47. for any care or treatment involving acupuncture

48. replacement of implanted cataract lenses

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

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

51. human growth hormones, unless Covered in the Schedule of Benefits

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

53. services that are always considered Cosmetic include, but are not limited to, (1) removal of tattoos; (2) facelifts; (3) body contouring or body modeling; (4) injections to smooth wrinkles; (5) piercing ears or other body parts; (6) rhytidectomy or rhytidoplasty; (7) thighplasty; (8) brachioplasty; (9) keloid removal; (10) dermabrasion; (11) chemical peels; and (12) laser resurfacing

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

55. Travel immunizations not received through Your pharmacy benefit

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

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

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

SECTION VI - CLAIMS AND PAYMENT

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

CLAIMS

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

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

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

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

CLAIMS BILLING

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

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

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

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

Not all Covered Services are available from Network Providers. There may be some Provider types that We do not contract with. These Providers are called Non-Contracted Providers. Claims for services received from Non-Contracted Providers are handled in the same manner as described above for Non-Network Providers. You also have the same responsibilities as described above.

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

A Network Provider, or a Non-Network Provider may refuse to render, or reduce

or terminate a service that has been rendered, or require You to pay for what You believe should be a Covered Service. If this occurs:

a. You may submit a claim to Us to obtain a Coverage decision concerning whether the Plan will Cover that service. For example, if a pharmacy (1) does not provide You with a prescribed medication; or (2) requires You to pay for that prescription, You may submit a claim to the Plan to obtain a Coverage decision about whether it is Covered by the Plan.

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

PAYMENT

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

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

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

b. We will pay benefits within 30 days after we receive a claim form that is complete. Claims are processed in accordance with current industry standards, and based on Our information at the time We receive the claim form. We are not responsible for over or under payment of claims if Our information is not complete or inaccurate. We will make reasonable efforts to obtain and verify relevant facts when claim forms are submitted.

c. When a claim is paid or denied, in whole or part, You will receive a Claim Summary, sometimes referred to as the Explanation of Benefits (EOB). The Claim Summary will describe how much was paid to the Provider, and also let You know if You owe an additional amount to that Provider. The administrator will send the Claim Summary to the last address on file for You.

d. You are responsible for paying any applicable Copayments, Coinsurance, or Deductible amounts to the Provider.

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

"INFORMATION PLEASE."

Whenever You need to file a claim, We can process it for You more efficiently if You complete a claim form. This will ensure that You provide all the

information needed. Most providers will have claim forms, or You can request them from Us by calling the customer service number shown on the membership ID card.

Mail all claim forms to:

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

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

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

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

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

2. Let Us know if You move.

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

SECTION VII - GRIEVANCE

GRIEVANCE PROCEDURE

I. INTRODUCTION

Our Grievance procedure (the "Procedure") is intended to provide a fair, quick and inexpensive method of resolving any and all Disputes with the Plan. Such Disputes include: any matters that cause You to be dissatisfied with any aspect of Your relationship with the Plan; any Adverse Benefit Determination concerning a Claim; or any other claim, controversy, or potential cause of action You may have against the Plan. Please contact the customer service department at the number listed on the membership ID card: (1) to file a Claim; (2) if You have any questions about this EOC or other documents related to Your Coverage (e.g., a Claim Summary, sometimes referred to as the Explanation of Benefits or Monthly Claims Statement); or (3) to initiate a Grievance concerning a Dispute.

- This Procedure is the exclusive method of resolving any Dispute. Exemplary or punitive damages are not available in any Grievance or litigation, pursuant to the terms of this EOC. Any decision to award damages must be based upon the terms of this EOC.
- The Procedure can only resolve Disputes that are subject to Our control.
- You cannot use this Procedure to resolve a claim that a Provider was negligent. Network Providers are independent contractors. They are solely responsible for making treatment decisions in consultation with their patients. You may contact the Plan, however, to complain about any matter related to the quality or availability of services, or any other aspect of Your relationship with Providers.
- You may request a form from the Plan to authorize another person to act on Your behalf concerning a Dispute.
- We, the Plan and You may agree to skip one or more of the steps of this Procedure if it will not help to resolve the Dispute.
- Any Dispute will be resolved in accordance with applicable Tennessee or Federal laws and regulations, the ASA and this EOC.

II. DESCRIPTION OF THE REVIEW PROCEDURES

A. Inquiry

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

B. First Level Grievance

You must submit a written request asking the Plan to reconsider an Adverse Benefit Determination, or take a requested action to resolve another type of Dispute (Your "Grievance"). You must begin the Dispute process within 180 days from the date We issue notice of an Adverse Benefit Determination from the Plan or from the date of the event that is otherwise causing You to be dissatisfied with the Plan. If You do not initiate a Grievance within 180 days of when We issue an Adverse Benefit Determination, We may raise Your failure to initiate a Grievance in a timely manner as a defense if You file a

lawsuit against the Administrator later.

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

- **Grievance Process**

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

- **Written Decision**

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

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

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

  (c) For a pre-service, urgent care claim, within 72 hours of receipt of Your request for review.

  The decision of the Committee will be sent to You in writing and will contain:

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

  (b) The basis of the committee's decision; and

  (c) Reference to the documentation or information upon which the committee based its decision. You may receive a copy of such documentation or information, without charge, upon written request.

C. Second Level Grievance

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

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

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

Your decision concerning whether to file a second level Grievance has no effect on Your rights to any other benefits under the Plan. If You file a second level Grievance concerning an ERISA Action, the

Plan agrees to toll any time defenses or restrictions affecting Your right to bring a civil action against the Plan until the second level committee makes its decision. Any person involved in making a decision concerning Your Dispute (e.g. first level committee members) will not be a voting member of the second level Grievance committee.

- **Grievance Process**

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

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

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

  (b) Information presented during the hearing. Second level Grievance committee members and You will be permitted to question each other and any witnesses during the hearing. You will also be permitted to make a closing statement to the committee at the end of the hearing.

- **Written Decision**

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

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

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

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

D. Independent Review of Medical Necessity Determinations

If Your Grievance involves a Medical Necessity determination, or grievances with respect to Emergency Care Services rendered at an out-of-network hospital, items and services rendered by an Out-of-Network Provider at an in-network hospital (unless You agreed with the Provider prior to the services to accept out-of-network terms under regulatory requirements) and Authorized air ambulance services, then either: (1) after completion of the mandatory first level Grievance; or (2) after completion of the mandatory first level Grievance followed by completion of the second level Grievance, You may request that the Dispute be submitted to a neutral third party, selected by Us, to independently review and resolve such Dispute(s). If You request an independent review following the mandatory first level Grievance, You waive Your right to a second level Grievance and Your right to present oral testimony during the Grievance Process. Your request for independent review must be submitted in writing within 180 days after the date You receive

notice of the decision. Receipt shall be deemed to have occurred no more than two days after the date of issuance of the decision. Any person involved in making a decision concerning Your Dispute will not be a voting member of the independent review panel or committee.

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

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

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

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

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

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

SECTION VIII - SUBROGATION AND RIGHT OF REIMBURSEMENT

A. Subrogation Rights

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

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

- the insurance of the injured party;
- the person, company (or combination thereof) that caused the illness or injury, or their insurance company; or
- any other source, including uninsured or 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 affected by any reductions due to Your negligence, nor by attorney fees and costs You incur.

B. Priority Right of Reimbursement

Separate and apart from the Plan's right of subrogation, the Plan shall have first lien and right to reimbursement. This reimbursement right attaches automatically as a lien against any proceeds received by You from a third-party for the cost of care or treatment for any injury or illness caused by the third party for which medical payment is provided. The Plan's first lien supersedes any right that You or Your estate may have to be "made whole". In other words, the Plan is entitled to the right of first reimbursement out of any recovery You or Your estate might procure regardless of whether You or Your estate have received compensation for any of Your damages or expenses, including Your or Your estate's attorneys' fees or costs. This priority right of reimbursement supersedes Your or Your estate's right to be made whole from any recovery, whether full or partial. In addition, You agree on behalf of Yourself and Your estate to do nothing to prejudice or oppose the Plan's right to subrogation and reimbursement and You acknowledge that the Plan precludes operation of the "made-whole", "attorney-fund", and "common-fund" doctrines. You agree on behalf of Yourself and Your estate to reimburse the Plan 100% first for any and all benefits provided through the Plan, and for any costs of recovering such amounts from 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 or their estate);
- Any auto or recreational vehicle insurance coverage or benefits including, but not limited to, uninsured or underinsured motorist coverage;
- Business and homeowner medical liability insurance coverage or payments.

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

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

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

<u>Notice and Cooperation</u>

Members are required to notify the administrator if they are involved in an incident that gives rise to such subrogation rights and/or priority right of reimbursement, to enable the

administrator to protect the Plan's rights under this section. Members are also required to cooperate with the administrator and to execute any documents that the administrator, acting on behalf of the Employer, deems necessary to protect the Plan's rights under this section.

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

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

Legal Action and Costs

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

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

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

Settlement or Other Compromise

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

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

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

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

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

promptly reimburse the Plan for amounts paid by the Plan. You should seek the advice of an attorney regarding the Plan's rights of subrogation and reimbursement.

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

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

BlueCross BlueShield of Tennessee, Inc.
Department of Subrogation

To whom it may concern:

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

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

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

Privacy Practices

Important Privacy Practices Notice

Effective Date: July 1, 2021

Important Privacy Information

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

Legal obligations

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

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

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

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

Sumner County Government Self Insurance Board
355 N Belvedere Drive
Room 302
Gallatin, TN 37066
615-452-2632
Fax: 615-452-7335
drobertson@sumnercountytn.gov

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

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

Organizations This Notice Covers

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

For additional information, including TTY/TDD users, please call (615)451-6033. Para obtener ayuda en español, llame al (615)451-6033**.**

How We May Use and Share Your Information

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

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

Ways We May Use and Share Your Information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

For example, we would need your written authorization for:

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

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

Your Individual Rights

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION IX - TERMINATION OF MEMBER COVERAGE

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

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

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

2. Termination of Coverage Due to Loss of Eligibility

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

3. Termination or Rescission of Coverage

The Plan may terminate Your Coverage, if:

1. You fail to make a required Member payment when it is due. (The fact that You have made a Payment contribution to the Employer will not prevent the administrator from terminating Your Coverage if the Employer fails to submit the full Payment for Your Coverage to the administrator when due); or

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

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

c. You have made a misrepresentation of fact 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.

At its discretion, the Plan may terminate or Rescind Coverage if You have made an intentional misrepresentation of material fact or committed fraud in connection with Coverage. If applicable, the Plan will return all Premiums paid after the termination date less claims paid after that date. If claims paid after the termination date are more than Premiums paid after that date, the Plan has the right to collect that amount from You or Your terminated dependents to the extent allowed by law. You will be notified thirty (30) days in advance of any Rescission.

4. Right to Request a Hearing

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

5. Payment For Services Rendered After Termination of Coverage

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

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

SECTION X - CONTINUATION OF COVERAGE

Federal Law

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

1. Eligibility

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

a. Subscribers. Loss of Coverage because of:

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

b. Covered Dependents. Loss of Coverage because of:

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

2. Enrolling for COBRA Continuation Coverage

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

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

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

3. Payment

You must submit any Payment required for COBRA Continuation Coverage to the administrator at the address indicated on Your Payment notice. If You do not enroll when first becoming eligible, the Payment due for the period between the date You first become eligible and the date You enroll for COBRA Continuation Coverage must be paid to the Employer (or to the administrator, if so directed by the Employer) within 45 days after the date You enroll for COBRA Continuation Coverage. After enrolling for COBRA Continuation Coverage, all Payments are due and payable on a monthly basis as required by the Employer. If the Payment is not received by the administrator on or before the due date, Coverage will be

terminated, for cause, effective as of the last day for which Payment was received as explained in the Termination of Coverage Section. The administrator may use a third party vendor to collect the COBRA Payment.

4. Coverage Provided

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

5. Duration of Eligibility for COBRA Continuation Coverage

   COBRA Continuation Coverage is available for a maximum of:

   - 18 months if the loss of Coverage is caused by termination of employment or reduction in hours of employment; or
   - 29 months of Coverage. If, as a qualified beneficiary who has elected 18 months of COBRA Continuation Coverage, You are determined to be disabled within the first 60 days of COBRA Continuation Coverage, You can extend Your COBRA Continuation Coverage for an additional 11 months, up to 29 months. Also, the 29 months of COBRA Continuation Coverage is available to all non-disabled qualified beneficiaries in connection with the same qualifying event. "Disabled" means disabled as determined under Title II or XVI of the Social Security Act. In addition, the disabled qualified beneficiary or any other non-disabled qualified beneficiary affected by the termination of employment qualifying event must.
     - Notify the Employer or the administrator of the disability determination within 60 days after the determination of disability, and before the close of the initial 18-month Coverage period; and
     - Notify the Employer or the administrator within 30 days of the date of a final determination that the qualified beneficiary is no longer disabled; or
   - 36 months of Coverage if the loss of Coverage is caused by:
     - the death of the Subscriber;
     - loss of dependent child status under the Plan;
     - the Subscriber becomes entitled to Medicare; or
     - divorce or legal separation from the Subscriber; or
   - 36 months for other qualifying events. If a Covered Dependent is eligible for 18 months of COBRA Continuation Coverage as described above, and there is a second qualifying event (e.g., divorce), You may be eligible for 36 months of COBRA Continuation Coverage from the date of the first qualifying event.

6. Termination of COBRA Continuation Coverage

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

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

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

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

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

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

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

8. Continued Coverage During a Military Leave of Absence

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

9. <u>The Trade Adjustment Assistance Reform Act of 2002</u>

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

SECTION XI - DEFINITION OF TERMS

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

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

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

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

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

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

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

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

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

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

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

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

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

Behavioral Health Services – Any services or supplies that are Medically Necessary and Medically Appropriate to treat: a mental or nervous condition; alcoholism; chemical dependence; drug abuse or drug addiction.

Billed Charges - means the amount that a Provider charges for services rendered. Billed Charges may be different from the amount that BlueCross determines to be the Maximum Allowable Charge for services.

Blue Distinction Centers for Transplants (BDCT) Network – A network of facilities and hospitals contracted with BlueCross (or with an entity on behalf of BlueCross) to provide Transplant Services for some or all organ and bone marrow/stem cell transplant procedures Covered under this EOC. Facilities obtain designation as a BDCT by

transplant type; therefore, a hospital or facility may be classified as a BDCT for one type of organ or bone marrow/stem cell transplant procedure but not for another type of transplant. This designation is important as it impacts the level of benefit You will receive.

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

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

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

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

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

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

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

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

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

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

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

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

Custodial Care - any services or supplies provided to assist an individual in the activities of daily living, as determined by the Plan including but not limited to eating, bathing, dressing or other self-care activities.

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

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

Dependent - spouse (under a legally existing marriage between two people) and children including adopted children and stepchildren who live with the Subscriber in a regular parent-child or guardianship relationship and are dependent on them for at least 50 percent of their support.

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

Durable Medical Equipment - equipment which:

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

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

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

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

Eligible Provider –

The following are considered Eligible Providers, under this coverage:

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

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

Prior Authorization for Covered Services (except initial maternity admission) must be obtained from the Administrator or benefits will be reduced or denied.

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

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

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

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

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

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

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

Emergency – A sudden and unexpected medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect to result in:

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

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

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

Emergency Care Services – Those services and supplies that are Medically Necessary and Medically Appropriate in the treatment of an Emergency and delivered in a hospital Emergency department or a licensed independent freestanding emergency department. Emergency Care Services may include items and services after the Member is stabilized and as part of outpatient observation or an inpatient or outpatient stay related to the Emergency.

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

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

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

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

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

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

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

Freestanding Dialysis Facility - a facility Other Provider that provides kidney dialysis treatment, maintenance, and training to patients on an Outpatient or Home Health Care basis. To be eligible for payment under this coverage, the facility must be approved by Medicare.

Health Care Professional - means a podiatrist, dentist, chiropractor, nurse midwife, registered nurse, optometrist, or other person licensed or certified to practice a health care profession, other than medicine

or osteopathy, by Tennessee or the state in which such provider practices.

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

To schedule a Health risk Assessment, contact One to One at 1-855-571-4500 or register online at www.sumnercountyhealth.com.

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

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

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

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

Approved Hospice refers to a Hospice which:

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

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

Incapacitated Child – an unmarried child who is, and continues to be, both (1) incapable of self-sustaining employment by reason of intellectual or physical disability (what used to be called mental retardation or physical handicap); and (2) chiefly dependent upon the Subscriber or Subscriber's spouse for economic support and maintenance.

If the child reaches this Plan's Limiting Age while Covered under this Plan, proof of such incapacity and dependency must be furnished within 30 days of when the child reaches the Limiting Age.

Incapacitated dependents of Subscribers of new groups, or of Subscribers who are newly eligible under this Plan, are eligible for Coverage if they were covered under the Subscriber's or the Subscriber's spouse's previous health benefit plan. We may ask You to furnish proof of the incapacity and dependency upon enrollment and for proof that the child continues to meet the conditions of incapacity and dependency, but not more frequently than annually.

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

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

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

Investigational – The definition of "Investigational" is based on the BlueCross and BlueShield of Tennessee's technology evaluation criteria. Any technology that fails to meet **ALL** of the following four criteria is considered to be Investigational.

a. The technology must have final approval from the appropriate governmental regulatory bodies, as demonstrated by:

   i. This criterion applies to drugs, biological products, devices and any other product or procedure that must have final approval to market from the U.S. Food and Drug Administration or any other federal governmental body with authority to regulate the use of the technology.

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

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

   i. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.

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

c. The technology must improve the net health outcome, as demonstrated by:

   i. The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.

d. The improvement must be attainable outside the Investigational settings, as demonstrated by:

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

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

a. Your medical records, or

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

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

d. the published authoritative medical or scientific literature regarding the proposed service or supply in connection with the treatment of injuries or illnesses such as those experienced by You, or

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

f. the opinions of any entities that contract with the Plan to assess and

coordinate the treatment of Members requiring non-experimental or Investigational services, or

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

Late Enrollee - an Employee or eligible Dependent who did not apply, or for whom application was not made, for coverage within 30 days after such person first became eligible for coverage under this plan.

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

Maximum Allowable Charge - The amount that the administrator, at its discretion, has determined to be the maximum amount payable for a Covered Service. For Covered Services provided by Network Providers, that determination will be based upon the administrator's contract with the Network Provider for Covered Services rendered by that Provider. For Covered Services provided by Out-of-Network Providers, the amount payable will be based upon the administrator's Out-of-Network fee schedule for the Covered Services rendered by Out-of-Network Providers, or as otherwise determined in accordance with the requirements of applicable state or federal law.

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

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

- be Medically Necessary;
- be consistent with generally accepted standards of medical practice for the Member's medical condition;
- be provided in the most appropriate site and at the most appropriate level of service for the Member's medical condition;
- not be provided solely to improve a Member's condition beyond normal variations in individual development, appearance and aging; and

not be for the sole convenience of the Provider, Member or Member's family.

Medically Necessary or Medical Necessity –"Medically Necessary" means procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice; and
- clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the patient, physician or other health care provider; and
- not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

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

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

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

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

Member Payment – The dollar amounts for Covered Services that You are responsible for as set forth in the Schedule of Benefits, including Copayments, Deductibles, Coinsurance and Penalties. The administrator may require proof that You have made any required Member Payment.

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

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

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

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

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

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

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

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

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

When the Network Out-Of-Pocket Maximum is reached, 100% is payable for

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

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

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

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

Penalty/Penalties –A reduction in benefit amounts paid by Us as a result of failure to comply with Plan requirements such as failing to obtain Prior Authorization for certain Covered Services shown in the Schedule of Benefits, as requiring such Prior Authorization. The Penalty will be a reduction in the Plan Payment for Covered Services and does not apply to the Out-of-Pocket Maximum.

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

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

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

Qualified Medical Child Support Order – A medical child support order, issued by a court of competent jurisdiction or state administrative agency, which creates or recognizes the existence of a child's right to receive benefits for which a Subscriber is eligible under the Plan. Such order shall identify the Subscriber and each such child by name and last known mailing address; give a description of the type and duration of coverage to be provided to each child; and identify each health plan to which such order applies.

Rescind or Rescission – A retroactive termination of Coverage because You committed fraud or made an intentional misrepresentation of a material fact in connection with Coverage. Actions that are fraudulent or an intentional misrepresentation of a material fact include, but are not limited to, knowingly enrolling or attempting to enroll an ineligible individual in Coverage, permitting the improper use of Your Member ID card, or claim fraud. A Rescission does not include a situation in which the Plan retroactively terminates Coverage in the ordinary course of business for a period for which You did not pay the Premium. An example would be if You left Your job on January 31, but Coverage was not terminated until March 15. In that situation, the Plan may retroactively terminate Your Coverage effective February 1 if You did not pay any Premium after You left Your job (subject to any right You may have to elect continuation coverage). This is not a Rescission.

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

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

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

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

will be considered a Skilled Nursing Facility under this plan.

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

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

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

Surgery - means the following:

operative and cutting procedures, including:

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

Telehealth – Remote consultation that meets Medical Necessity criteria.

Totally Disabled or Total Disability – Either:

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

A Covered Dependent who is prevented from engaging in substantially all of the normal activities of a person of like age and sex in good health because of non-occupational injury or disease.

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

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

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

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

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

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

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

IMPORTANT NOTICE FOR MASTECTOMY PATIENTS

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

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

The Coverage will be provided subject to the same Coinsurance, Copays and Deductibles established for other benefits under this plan. Please refer to the Covered Services section of this EOC for details.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

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

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

The company office or person to contact about coverage is:

_____

Name:

_____

Address:

_____

_____

_____

Phone:

The BlueCross BlueShield Plan to contact is:

Address: BlueCross BlueShield of Tennessee
1 Cameron Hill Circle
Chattanooga, TN 37402-2555

The Subscriber Number shown on my identification card is:

_____

The "Effective Date" when my coverage begins is:

_____