BLUE SELECT

EVIDENCE OF COVERAGE

Clarksville – Montgomery County
Employees Insurance Trust

Active Employees

BlueCross BlueShield of Tennessee

An Independent Licensee of the
BlueCross BlueShield Association

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

Notice to Member:

Regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) require that a Member be given credit under certain conditions for the time covered under previous health benefit program coverage.

Such "Creditable Coverage" may be used to reduce the waiting period for Pre-existing Conditions. However, it will be the Member's responsibility to advise the Employer of any Creditable Coverage and provide any required documentation. The Employer, in turn, will advise the Member as to the date of the Pre-existing Condition limitation ends.

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

TABLE OF CONTENTS

SCHEDULE OF BENEFITS - Clarksville – Montgomery County Employees Insurance Trust 1
SPECIAL PROVISIONS 5
PRESCRIPTION DRUG PROGRAM 7
CASE MANAGEMENT 11

SECTION I - ELIGIBILITY 12
COVERAGE FOR YOU 12
COVERAGE FOR YOUR DEPENDENTS 12
TYPES OF COVERAGE AVAILABLE 12
ELIGIBLE EMPLOYEES 12
ELIGIBLE RETIRED AND DISABILITY RETIRED EMPLOYEES 12
DEPENDENTS OF A DECEASED EMPLOYEE 13
EFFECTIVE DATE 13
APPLYING FOR COVERAGE 13
CHANGING COVERAGE 14
REINSTATEMENT FOR MILITARY PERSONNEL RETURNING 15

SECTION II - BLUECARD/BLUECARD PPO PROGRAM 16

SECTION III - COST CONTAINMENT FEATURES: WHAT THEY ARE/HOW TO USE THEM 18
WHAT YOU CAN DO TO CONTAIN COSTS 18
PRIOR AUTHORIZATION 18
CONCURRENT UTILIZATION REVIEW 18
DURABLE MEDICAL EQUIPMENT 18

SECTION IV - YOUR BENEFITS 19
HOSPITAL AND OTHER FACILITY PROVIDER SERVICES 19
PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES 20
OTHER SERVICES 21

SECTION V - LIMITATIONS/EXCLUSIONS 27

SECTION VI - CLAIMS AND PAYMENT 30
CLAIMS 30
CLAIMS BILLING 30
PAYMENT 31
ASSIGNMENT 31
"INFORMATION PLEASE.." 31

SECTION VII - GRIEVANCE 33
GRIEVANCE PROCEDURE 33
DESCRIPTION OF THE REVIEW PROCEDURES 34

SECTION VIII - RIGHTS OF RECOVERY AND REIMBURSEMENT 37
RIGHT OF RECOVERY. 37
LIEN 37

NOTICE AND COOPERATION. 37

SECTION IX - TERMINATION OF MEMBER COVERAGE....38
CONTINUATION COVERAGE....38
LEAVE OF ABSENCE 38
BENEFITS AFTER COVERAGE ENDS 38

SECTION X - DEFINITION OF TERMS 39

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT 47

IMPORTANT NOTICE FOR MASTECTOMY PATIENTS....47

UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994....47

INTRODUCTION

This Evidence of Coverage (this "EOC") is included in the Summary Plan Description document (SPD) created by 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 BCBST. The pronouns "we", "us", and "our" used throughout this EOC refer to BCBST. Your Employer has entered into an Administrative Services Agreement (ASA) with BCBST for it to administer the claims Payments under the terms of the SPD, and to provide other services. BCBST does not assume any financial risk or obligation with respect to Plan claims. BCBST is not the Plan Sponsor, the Plan Administrator or the Plan Fiduciary. 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.

While the Employer has delegated discretionary authority to make any benefit or eligibility 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, whether or not the Employer's benefit plan is subject to ERISA.

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

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

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

RELATIONSHIP WITH PARTICIPATING PROVIDERS

1. Independent Contractors

Participating Providers are not Employees, agents or representatives of the administrator. Such Providers contract with the administrator, which has agreed to pay them for rendering Covered Services to Members. Participating 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 as that term is defined in ERISA, has the discretionary authority to make the final determination regarding the terms of Your Coverage ("Coverage Decisions"). Both the administrator and the Employer make Coverage Decisions based on the terms of this EOC, the ASA, the administrator's Participation Agreements with Participating Providers, and applicable State or Federal laws.

The administrator's Participation Agreements permit Participating Providers to dispute Coverage Decisions if they disagree with those Decisions. If Your Participating Provider does not dispute a Coverage Decision, You may request reconsideration of that Decision as explained in the Grievance Procedure section of this EOC. The Participation Agreement requires Participating Providers to fully and fairly explain Coverage Decisions to You, upon request, if You decide to request that the administrator reconsider a Coverage Decision.

The administrator has established various incentive arrangements to encourage Participating Providers to provide Covered Services to You in an appropriate and cost effective manner. You may request information about Your Provider's Payment arrangement by contacting the administrator's Customer Service Department.

2. Termination of Providers' Participation

The administrator or a Participating Provider may end their relationship with each other at any time. A Participating 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 Participating Provider will be available to render services while You are covered.

SCHEDULE OF BENEFITS -
Clarksville – Montgomery County Employees Insurance Trust

Group Number: 90045

Benefits Effective: September 1, 2011

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

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

DEDUCTIBLE

Deductible to be applied to:	Network Provider	Non-Network Provider
Individual Deductible Maximum	$350	$350
Two-Person Deductible Maximum	$700	$700
Family Deductible Maximum	$875	$875

Combined - Network/ Non-Network Deductibles:	
Individual	$350
Two-Person	$700
Family	$875

The Deductible will be waived for accidental injuries.

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

Coinsurance to be applied to:	Network Provider	Non-Network Provider
All Covered Services after Deductible has been satisfied (unless otherwise specified)	90%	70%
Inpatient Rehabilitation Services, limited to 100 days per calendar year.	90%	70%
Preventive Services Under age 6	100%	70% after Deductible has been satisfied
Preventive Services Age 6 and over	100%	70% after Deductible has been satisfied
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:

	Network	**Non-Network:**
Individual	$1,350	$4,050
2-Person	$2,700	$8,100
Family	$2,700	$8,100

Psychiatric Care Maximums	**Network Provider**	**Non-Network Provider**
Inpatient Benefits payable per Benefit Period limited to 30 days	80%	60%
Outpatient Benefits payable per Benefit Period limited to 35 visits	50%	50%
Benefits will not be provided for more than two Inpatient stays for Substance Abuse Treatment.		

Mental Health Medication Management Benefit: Outpatient treatment visits for Medication Management does not count toward the number of mental health outpatient visits per year. Medication Management means pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy.

Two (2) Residential Treatment days for one (1) inpatient day.

Organ Transplant Services			
Organ Transplant Services, all transplants except kidney	**In-Transplant Network benefits**: 90% after Network deductible, Network Out –of-Pocket Maximum applies	**Network Providers not in Our Transplant Network** 90% of Transplant Maximum Allowable Charge TMAC) after Network Deductible, Network Out-of-pocket Maximum applies, amounts over TMAC do not apply to the Out-of-pocket maximum and are not covered.	**Out-of-Network Providers** - 60% of Transplant Maximum Allowable Charge (TMAC), after Out-of-Network Deductible, Out-of Network Out-of- Pocket Maximum applies, amounts over TMAC do not apply to the Out-of- Pocket and are not covered.
Organ Transplant Services, kidney transplants	**Network Providers –** 90% after Network Deductible; Network Out-of-Pocket Maximum applies		**Out-of-Network Providers**: 60% of Maximum Allowable Charge (MAC), after Out-of-Network Deductible, Out-of Network Out-of- Pocket Maximum applies, amounts over MAC do not apply to the Out-of- Pocket and are not covered.
Network Providers not in our Transplant Network include Network Providers in Tennessee and BlueCard PPO Providers outside Tennessee.			

The Annual Maximum Amount Payable for Network and/or Non-Network Provider Services is $2,000,000.

OTHER PROVISIONS

The waiting period before benefits are payable for a Pre-existing Condition will be 12 months. This period may be reduced by any Creditable Coverage.

ADDITIONAL BENEFITS

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

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

SPECIAL PROVISIONS

1. Benefits will be payable at 50% for covered expenses rendered in connection with correction of nerve interference and its effects by manual or mechanical means where the interference results from or is related to distortion, misalignment, or subluxation of or in the vertebral column (spinal manipulation therapy). Services limited to 30 visits per Benefit Period. The 50% Coinsurance will not apply to any Out-of-Pocket maximums.
2. Benefits will be available, subject to the Deductible and Coinsurance, for Orthotics for the foot, including shoe inserts, braces, molded shoes or appliances.
3. Benefits will be available for the office visit in connection with an annual cervical cancer screening.
4. Benefits will be available for annual screening for men treated for prostate cancer, men over 45 with enlarged prostates, and for men of any age with prostate nodules or other irregularities. The PSA test will be the primary screening tool of men over 50 and the transrectal ultrasound will be covered for those with elevated PSA levels.
5. Benefits will be available, beginning at age 50, for colorectal screenings as follows:
   a. Yearly fecal occult blood test (FOBT).
   b. Flexible sigmoidoscopy every 5 years.
   c. Yearly FOBT and flexible sigmoidoscopy every 5 years (preferred over either test alone).
   d. Double contrast barium enema every 5 years.
   e. Colonoscopy every 10 years.
6. Benefits will be available, subject to the Deductible and Coinsurance and the criteria below, for the following four surgical procedures for the treatment of morbid obesity:
   a. Vertical banded gastroplasty accompanied by gastric stapling. Restricts the size of the stomach using a stapling technique. There is no rearrangement of the intestinal anatomy.
   b. Gastric segmentation along the vertical axis with a Roux-en-Y bypass with distal anastomosis placed in the jejunum. Restricts the size of the stomach by stapling shut 90% of the lower stomach. The proximal intestinal anatomy is rearranged, thereby bypassing the duodenum.
   c. Gastric banding. Involves placing a gastric band around the outside of the stomach. The stomach is not entered.
   d. Duodenal switch/biliopancreatic bypass. A variant of the biliopancreatic bypass. Instead of performing a distal gastrectomy, a “sleeve” gastrectomy is performed along the vertical axis of the stomach. The sleeve gastrectomy decreases the volume of the stomach and the parietal cell mass. This procedure is only appropriate for persons with a BMI in excess of 60.

The following criteria must be met before benefits are available for the procedures listed above:

a. Presence of morbid obesity that has persisted for a least five (5) years, defined as either:

- Body mass index (BMI) exceeding forty (40); or
- More than one hundred (100) pounds over one's ideal body weight as provided in the 1983 Metropolitan Life Height and Weight table; or
- BMI greater than thirty-five (35) in conjunction with the following severe co-morbidities that are likely to reduce life expectancy:
  - Coronary artery disease; or
  - Type 2 diabetes mellitus; or
  - Obstructive sleep apnea; or
  - Three or more of the following cardiac risk factors:

    (1) Hypertension (BP>140 mmHg systolic and/or 90mmHg diastolic)

    (2) Low high-density lipoprotein cholesterol (HDL less than 40mg/dL)

    (3) Elevated low-density lipoprotein cholesterol (LDL>100 mg/dL)

    (4) Current cigarette smoking

    (5) Impaired glucose tolerance (2 hour blood glucose>140 mg/dL on an oral glucose tolerance test)

    (6) Family history early cardiovascular disease in first degree relative (myocardial infarction at age under fifty (50) in male relative or at age under sixty-five (65) for a female relative)

    (7) Age greater than forty-five (45) years in men and fifty-five (55) years in women; or
- Body Mass Index exceeding 60 for consideration of the duodenal switch/biliopancreatic bypass procedure.

b. History of failure of medical/dietary therapies (including low calorie diet, increased physical activity and behavioral reinforcement). This attempt as conservative management must be within two (2) years prior to surgery, and must be documented by an attending physician who does not perform bariatric surgery. (Failure of conservative therapy is defined as an inability to lose more than ten (10) percent of body weight over a six (6) month period and maintain weight loss).

c. There must be documentation of Medical evaluation of the individual for the condition of morbid obesity and/or its co-morbidities by a physician other than the operating surgeon and his/her associates, and documentation that this evaluating physician concurs with the recommendation for bariatric surgery.

Prior Authorization is required. BCBST will determine if all the criteria have been met before approving surgery.

7. Benefits are available for dietary counseling for medical conditions other than diabetes, limited to 6 visits per Benefit Period and payable as Preventive Services.
8. Benefits are available for tobacco cessation counseling, limited to 8 visits per Benefit Period and payable as Preventive Services.

HEALTHY FOCUS PROGRAM

Healthy Focus is a disease management program available through the Employer and managed by LifeMasters Supported Self Care. Through this program, You can receive extra resources and personalized attention to help manage chronic health conditions and help You take better care of Yourself. Participation in the program is voluntary.

PRESCRIPTION DRUG PROGRAM

Definitions

1. **Average Wholesale Price** – A published suggested wholesale price of the drug by the manufacturer.
2. **Brand Name Drug** - a Prescription Drug identified by its registered trademark or product name given by its manufacturer, labeler or distributor.
3. **Compound Drug** – An outpatient Prescription Drug, which is not commercially prepared by a licensed pharmaceutical manufacturer in a dosage form approved by the Food and Drug Administration (FDA) and which contains at least one ingredient classified as an outpatient Prescription Drug.
4. **Covered Drug Expenses** – Covered Drug Expenses will be the lesser of: (a) the Maximum Allowable Charge (MAC) plus any dispensing fees and applicable sales tax; or (b) the Average Wholesale Price less any negotiated discounts plus any applicable dispensing fees and applicable sales tax.
5. **Drug Copayment** - the amount of the Covered Drug Expense of a Prescription Drug, which is the obligation of the Member. The Drug Copayment is paid directly to the Participating Pharmacy at the time 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.
6. **Drug Formulary** - a list designating which Prescription Drugs and drug products are approved for reimbursement. This list is subject to periodic review and modification by BCBST.
7. **Experimental and/or Investigational Drugs** – Drugs or medicines, which are labeled: Caution – limited by federal law to Investigational use.
8. **Generic Drug** - a Prescription Drug included in the Approved Manufacturers List of the Tennessee Department of Health and Environment and which can be legally substituted for a trade or Brand Name Drug prescribed under applicable law. Generic Drugs must be AB rated by the FDA.
9. **Legend Drugs** – A drug that, by law, can be obtained only by Prescription and bears the label, "Caution: Federal law prohibits dispensing without a Prescription.
10. **Maintenance Drug** – Prescription Drugs most commonly used for selected disease states that are considered long term, chronic, and stable. BCBST maintains a list of Maintenance Drugs, which is reviewed periodically by Our Pharmacy and Therapeutics Committee. In keeping with accepted standards of medical practice, not all-therapeutic classes are included on the Maintenance Drug Prescription list.
11. **Managed Dosage Limitation –** Quantity limitations applied to certain Prescription Drug products as determined by the Pharmacy and Therapeutics Committee.
12. **Maximum Allowable Charge** – the amount that the Plan, at its sole discretion, has determined to be the maximum amount payable for a Covered Service. That determination will be based upon the Plan's contract with a Participating Provider or the amount payable based on the Plan's fee schedule for the Covered Services rendered by Non-Participating Providers.
13. **Non-Participating Pharmacy** - a Pharmacy which has not entered into a service agreement with BCBST or its agent to provide benefits at specified rates to Members.

14. **Non-Preferred Brand Drug or Elective Drug** - a Brand Name Drug that is not considered a Preferred Drug by the administrator. Usually there are lower cost alternatives to some Brand Name Drugs.
15. **Participating Pharmacy** - a Pharmacy which has entered into a Participating Pharmacy Agreement with BCBST or its agent to provide Prescription Drug benefits to Members, either in person or through home delivery.
16. **Pharmacy** - a state or federally licensed establishment which is physically separate and apart from the office of a physician or authorized Practitioner, and where Legend Drugs are dispensed by Prescription to the general public by a pharmacist licensed to dispense such drugs and products under the laws of the state in which he or she practices.
17. **Pharmacy and Therapeutics Committee or P&T Committee**– A panel of BCBST participating pharmacists, Participating 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) Maintenance Drug list; (4) Prior Authorization Drugs list; and (5) Managed Dosage Limitation list. The P&T Committee may also set dispensing limits on medications.
18. **Preferred Brand Drug** - Brand Name Drugs that the Plan has reviewed for clinical appropriateness, safety, therapeutic efficacy, and cost effectiveness. The Preferred Brand Drug list is reviewed at least annually by the P&T Committee.
19. **Prescription Drug** - a medication containing at least one Legend Drug which may not be dispensed under applicable state or federal law without a Prescription, and/or insulin.
20. **Prescription** - a written or verbal order issued by a physician or duly licensed Practitioner practicing within the scope of his or her licensure to a pharmacist for a drug, or drug product to be dispensed.
21. **Prior Authorization Drugs**- Prescription Drugs which are only eligible for reimbursement after prior approval from BCBST as determined by the P&T Committee.
22. **Step Therapy Limitations** – 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; and (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.

Covered Services

Prescription Drugs prescribed to a Member who is not confined in a hospital or other facility. Prescription Drugs must be:

- prescribed on or after the Member's coverage begins;
- approved for use by the Food and Drug Administration (FDA);
- dispensed by a licensed pharmacist;
- listed on the Drug Formulary; and
- not available for purchase without a Prescription.

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

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

Benefit Payment

Your pharmacy benefit plan requires Generics First Step Therapy for certain drug classes. You will need to try a generic drug from these drug classes before you try a more expensive brand-name drug in the same class. Although you have the option of purchasing the more expensive brand-name drug without Step Therapy, doing so will require you to pay the full cost of the drug without it being considered an eligible expense under the plan. The classes of drugs are:

Angiotensin II Receptor Blockers (ARBs)

ACE inhibitors

ACE inhibitors with calcium channel blockers

ACE inhibitors with diuretics

Analgesics

Angiotensin II Receptor Blockers (ARBs) with diuretics

Antidepressants

beta blockers

calcium channel blockers

lipid lowering agents (HMG Co-A reductase inhibitors)

proton pump inhibitors (PPIs)

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.

After a Calendar Year Drug Deductible of $75 per Member, benefit payment for Covered Services will be determined as follows:

- *Generic Drug*. We will determine the lesser of the billed charge or Maximum Allowable Charge, and pay 100%, up to the Maximum Allowable Charge. The Deductible will be waived for Generic Drugs.
- *Preferred Brand Drug*. We will determine the lesser of the billed charge or Maximum Allowable Charge, subtract the Drug Copayment of 10% for Active Employees and pay the difference up to the Maximum Allowable Charge. For a supply greater than 60 days, we will subtract 6% and pay the difference up to the Maximum Allowable Charge.
- *Non-Preferred Brand Name Drug*. We will determine the lesser of the billed charge or Maximum Allowable Charge, subtract the Drug Copayment of 20% for Active Employees and pay the difference up to the Maximum Allowable Charge. For a supply greater than 60 days, we will subtract 13% and pay the difference up to the Maximum Allowable Charge.

Benefits will be provided for up to a 30 calendar day supply of Prescription Drugs or up to a 100 calendar day supply of Maintenance Drugs or up to a 102 calendar day supply of Prescription Drugs obtained through home delivery. Some products may be subject to additional Managed Dosage limitations as adopted by BCBST.

If a Member has a Prescription filled at a Non-Participating Pharmacy, the Member must pay all expenses and file a claim for reimbursement with BCBST. The Member will be reimbursed based on the Maximum Allowable Charge, less any applicable Drug Deductible and/or Drug Copayment amount.

Subject to a Calendar Year Out-of-Pocket Maximum of $750 per Member, including Drug Deductible.

LIMITATIONS

- Refills must be dispensed pursuant to a Prescription. If the number of refills is not specified in the Prescription, benefits for refills will not be provided beyond one year from the date of the original Prescription.
- Drugs for the treatment of onychomycosis (e.g., nail fungus) are not Covered, except for: (1) diabetics; or (2) immuno-compromised patients.
- Growth hormones are not Covered, except for: (1) treatment of absolute growth hormone deficiency in children whose epiphyses have not closed; and (2) patients with "Turner" syndrome, including the drugs, (1) Genotropin; (2) Humatrope; (3) Norditropin; (4) Nutropin; (5) Saizen; (6) Serostim; (7) Somatropin; and (8) Protropin (Somatrem);
- Any Prescription and non-Prescription medical supplies, devices and appliances, other than syringes used in conjunction with injectable medications or other supplies used in the treatment of diabetes and/or asthma;
- Immunizations or immunological agents, including but not limited to: (1) biological sera, (2) blood, (3) blood plasma; or (4) other blood products except as required by hemophiliacs; and,
- Injectable drugs, except when: (1) intended for self-administration; or (2) defined by the Plan.
- Compound Drugs are Covered only when filled at a Network Pharmacy. The Network Pharmacy must submit the claim through the Plan's pharmacy benefit manager. The claim must contain a valid national drug code (NDC) number for at least one ingredient in the Compound Drug.

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

- drugs which are prescribed, dispensed or intended for use while the Member is confined in a hospital, skilled nursing facility or similar facility;
- any drugs, medications, Prescription devices or vitamins, available over-the-counter that do not require a Prescription by Federal or State law are excluded except as otherwise Covered in the EOC;
- any quantity of Prescription Drugs which exceed that specified by BCBST Pharmacy and Therapeutics Committee;
- any Prescription Drug purchased outside the United States, except those authorized by BCBST;
- non-oral contraceptives, contraceptive materials, Norplant and other implantable products, injectables, or devices; including those medications intended to terminate a pregnancy (e.g. RU-486);
- non-medical supplies or substances, including support garments, regardless of their intended use;
- artificial appliances;
- any drugs or medicines dispensed more than one year following the date of the Prescription;
- Prescription Drugs a Member is entitled to receive without charge in accordance with any worker's compensation laws or any municipal, state, or federal program;
- replacement Prescriptions resulting from lost, spilled, stolen, or misplaced medications (except as required by applicable law);
- drugs dispensed by a Provider other than a Pharmacy;

- administration or injection of any drugs;
- Prescription Drugs used for the treatment of infertility;
- Prescription Drugs not on the Drug Formulary;
- anorectics (any drug or medicine for the purpose of weight loss and appetite suppression);
- all newly FDA approved drugs prior to review by BCBST's Pharmacy & Therapeutic Committee;
- Compound Drugs filled or refilled at an Out-of-Network Pharmacy and not containing at least one ingredient requiring a Prescription or refill, identified with a valid national drug code (NDC) number;
- 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;
- Prescription Drugs used for cosmetic purposes including, but not limited to: (1) drugs used to reduce wrinkles (e.g. Renova); (2) drugs to promote hair-growth; (3) drugs used to control perspiration; (4) drugs to remove hair (e.g. Vaniqa); and (5) fade cream products;
- drugs used to enhance athletic performance;
- Experimental and/or Investigational Drugs; and
- 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.

CASE MANAGEMENT

BCBST will identify potential cases for case management, evaluate the complicated, chronic and/or catastrophic health care needs of Members and will coordinate the delivery of care when BCBST, in its sole discretion, determines that care is Medically Necessary and cost effective. Benefits provided shall not exceed the lifetime maximum specified and will be offered only in accordance with a plan of treatment with which the Member (or the Member's legal guardian) and the attending Physician concur.

Case management services will be made available on a case-by-case basis to individual Members. Under no circumstances does a Member acquire a vested interest in continued receipt of a particular benefit or level of benefits. Offer or confirmation of alternative benefits or modes of care in one instance shall not obligate BCBST to provide the same or similar benefits for any other Member in another instance. In addition, nothing herein shall be deemed a waiver of BCBST's right to enforce this plan in strict accordance with its express terms and conditions.

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 BCBST 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:

- be a permanent Employee regularly scheduled to work a minimum of 15 hours per week; or
- Be a Board Members who applied for coverage on or before July 1, 2001.

ELIGIBLE RETIRED AND DISABILITY RETIRED EMPLOYEES

To be eligible for coverage a Retired or Disability Retired Employee must:

- be a service or early Retiree under the Tennessee Consolidated Retirement System (TCRS) who terminated employment and who is eligible to receive TCRS retirement benefits and who has:
  - twenty or more total years of employment with two years of medical coverage in this Plan immediately prior to retirement, provided the period of time between the Employee's final termination date and the date retirement benefits commence (retirement date) may be up to five years; or
  - ten, but less than 20, total years of employment, with three continuous years of medical coverage in this Plan immediately prior to retirement, provided the date retirement benefits commence (retirement date) must immediately follow the Employee's date of final termination from employment.

Employees approved under these provisions may continue coverage until the earlier of the Employee's 65th birthday or he/she qualifies for Medicare. They must elect to continue medical coverage within 31 days of application for retirement benefits and will pay the appropriate contribution for Retirees as set by the Insurance Trust. For Employees who elected Two-Person or Family coverage, coverage may be continued on (1) their eligible Dependent Spouse until the earlier of the Dependent Spouse's attainment of age 65 or he/she qualifies for Medicare, and (2) their eligible Dependent Children until the child reaches the Dependent Child Limiting Age or qualifies for Medicare.

- If TCRS Retirees do not elect to continue medical coverage within the 31-day application period for retirement benefits, they may continue coverage only if approved as a Late Enrollee by Blue Cross-Blue Shield.
- Retired Employees must remain continuously enrolled in the Clarksville group plan after retirement. If they retire, then decide to teach at another school system, they cannot drop coverage and later re-enroll in the Clarksville Plan.
- For Employees who have attained age 65 or qualified for Medicare when applying for retirement benefits, they can continue Two-Person or Family coverage on their eligible Dependents only if they had elected such coverage

prior to the time retirement benefits were applied for.

- Spouses of TCRS Retirees can be covered under the Plan only if the TCRS Retiree was covered under the plan.
- If a TCRS Retiree was covered under the Plan and elected single coverage at the time retirement benefits were applied for, and subsequently acquired new Dependents as defined by the Dependent eligibility guidelines of this Plan, he/she can elect to cover these Dependents until the earlier of the TCRS Retiree's attainment of age 65 or he/she qualifies for Medicare.
- If a TCRS Retiree should predecease or divorce his/her Spouse, and subsequently remarry while covered under the Plan, he/she can cover himself/herself and his/her new Dependents until the earlier of his/her attainment of age 65 or he/she qualifies for Medicare.
- If a TCRS Retiree's Spouse should predecease or divorce the Retiree, and subsequently remarries while covered under the Plan, he/she can continue coverage on himself/herself and his/her eligible Dependents under the earlier of the Spouse's attainment of age 65 or he/she qualifies for Medicare.
- If a TCRS Retiree should initially qualify for Medicare, then lose Medicare coverage as a result in improvement in his/her medical condition, he/she will be allowed to re-enroll in the Plan until the earlier of attainment of age 65 or he/she re-qualifies for Medicare.
- The Insurance Trust reserves the right to amend or terminate the Plan or change contributions at any time, for any reason, and without notice. There is neither vesting in benefits nor a vested right to benefits.
- be a Disability Retiree meeting the required specified conditions.

To be eligible to continue coverage, the Retiree must be receiving a monthly retirement benefit from TCRS and cannot be eligible for Medicare.

DEPENDENTS OF A DECEASED EMPLOYEE

Coverage for the Dependents of a deceased Employee will remain in force until the end of the month in which the Employee's death occurred. Coverage will then be available under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

EFFECTIVE DATE

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

If You have met the eligibility requirements and You and Your Eligible Dependents apply when first eligible (or within 31 days), Your coverage will be effective on the next Effective Date BCBST bills Your Employer. 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 BCBST and You have been issued an identification card or have received other written notice that Your coverage is in effect.

APPLYING FOR COVERAGE

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

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

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

b. The unmarried, natural, legally adopted, 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 unmarried child, as defined above, who is within the age limit stated in the Schedule of Benefits and is a full-time student as determined by the accredited educational institution in which the child is enrolled; or

e. An unmarried child, as defined above, who is, and continues to be, both (1) incapable of self-sustaining employment by reason of mental or physical handicap, and (2) chiefly dependent upon the Subscriber for economic support and maintenance, provided proof of such incapacity and dependency is furnished within 31 days of the child's attainment of the applicable Limiting Age and subsequently as may be required by BCBST, but not more frequently than annually. In addition, such unmarried child must be a Dependent enrolled under this Plan or another plan (with no break in coverage, or no break greater than 63 days) prior to attaining the applicable Limiting Age.

BCBST's determination of eligibility under the terms of this provision shall be conclusive. BCBST 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 BCBST harmless from claims, losses, or suits relating to eligibility or insurability of any applicant, Subscriber, Employee or Dependent in administering this provision.

CHANGING COVERAGE

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

When You need to make a change, You should (1) tell Your employer, and (2) apply for any needed change within 31 days of the change in family status, date the new Dependent is acquired, etc.

A newborn child of the Subscriber or Subscriber's spouse is a Covered Dependent from the moment of birth. The Subscriber must enroll that child within 31 days of the date of birth. If the Subscriber fails to do so, and an additional Payment is required to cover that child, the Plan will not provide Coverage for that child after 31 days from the child's date of birth.

Changes in coverage will begin on the next Effective Date BCBST bills Your employer for this coverage (normally the first day of the month). Coverage for new Dependents added begins on the date the Dependent is acquired if the application is received within 31 days after that date.

If You Did Not Enroll On Time

If You wait more than 31 days from the date You are first eligible to apply or add a Dependent You and or the Dependent will be considered a Late Enrollee and will not be eligible for benefits in connection with a Pre-existing Condition until after the Pre-existing Condition Waiting Period has ended. Coverage for You or the Dependent will otherwise be effective on the next billing date following our receipt of the application for Coverage.

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

- he or she already had other health care coverage at the time coverage under this plan was previously offered; and
- he or she stated in writing at that time that such other coverage was the reason for declining coverage under this plan; and
- such other coverage is exhausted (if the previous coverage was continuation coverage under COBRA)

or the other coverage was terminated because he or she ceased to be eligible or employer contributions for such coverage ended; and

- he or she applies for coverage under this plan within 31 days after the loss of the other coverage.

Dependents who become eligible for coverage under this plan by reason of marriage, birth, adoption or placement for adoption after the Subscriber's Effective Date will not be considered Late Enrollees, provided application is made by the Subscriber on behalf of such person(s) within 31 days of the marriage, birth, adoption or placement for adoption.

REINSTATEMENT FOR MILITARY PERSONNEL RETURNING FROM ACTIVE SERVICE

An employee who returns to the Employer’s active payroll following active military duty may reinstate insurance coverage on the earliest of the following:

- The first day of the month which includes the date on which the military person was discharged from active duty;
- The first of the month following the date of discharge from active duty;
- The date on which the military person returns to the employers active payroll;
- The first of the month following the military persons return to the employer’s active payroll.

If coverage is reinstated before the employee returns to the Employer’s active payroll, the employee must pay 100 percent of the total premium. In all instances, employees must pay whole month premiums.

Reinstatement of coverage is not automatic. Returning military personnel must reapply within 90 days from the end of their leave before coverage can be reinstated. No pre-existing condition provision or waiting period requirements will apply.

SECTION II - BLUECARD/BLUECARD PPO PROGRAM

When You are in an area where Our Network Providers are not available and You need health care services or information about a BlueCross BlueShield PPO physician or hospital, just call the BlueCard/BlueCard PPO Participating Doctor and Hospital Information Line at 1-800-810-BLUE (2583.)

We will help You locate the nearest BlueCard/BlueCard PPO Participating Provider.

If You call 1-800-810-BLUE (2583), **and** go to a BlueCard/BlueCard PPO Participating Physician or Hospital, Your benefits will be Covered as In-network benefits, and Your out-of-pocket expenses will be less than if You go to a non- BlueCard/BlueCard PPO Participating Provider or Hospital.

In the BlueCard/BlueCard PPO Program, the term "Host Plan" means the BlueCross BlueShield Plan that provides access to service in the location where You need health care services.

Show your membership ID card (that has the "PPO in a suitcase" logo) to any BlueCard/BlueCard PPO Participating Provider. The BlueCard/BlueCard PPO Participating Provider can verify your membership, eligibility and Coverage with Your BlueCross BlueShield Plan. When You visit a BlueCard/BlueCard PPO Participating Provider, You should not have claim forms to file. After You receive services, Your claim is electronically routed to BCBST, which processes it and sends You a detailed explanation of benefits. You are responsible for any applicable Copayments, or Your Deductible and Coinsurance payments (if any.) If We pay such amounts to a healthcare provider on Your behalf, We may collect those cost-sharing amounts directly from You.

The calculation of Your liability for claims incurred outside Our service area which are processed through the BlueCard/BlueCard PPO Program will typically be at the lower of the provider's Billed Charges or the negotiated price We pay the Host Plan.

The negotiated price We pay to the Host Plan for health care services provided through the BlueCard/BlueCard PPO Program may represent either: (a) the actual price paid by the Host Plan on such claims; (b) an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the Host Plan's health care Providers or one or more particular Providers; or (c) a discount from Billed Charges representing the Host Plan's expected average savings for all of its Providers or for a specified group of Providers. The discount that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price.

Plans using either the estimated price or average savings factor methods may prospectively adjust the estimated or average price to correct for over- or underestimation of past prices. However, the amount You pay is considered a final price.

In addition, laws in certain states may require BlueCross and/or BlueShield Plans to use a basis for calculating Member liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Thus, if You receive Covered Services in these states, Your liability for Covered Services will be calculated using these states' statutory methods.

REMEMBER: YOU ARE RESPONSIBLE FOR RECEIVING PRIOR AUTHORIZATION FROM US. IF PRIOR AUTHORIZATION IS NOT RECEIVED, YOUR BENEFITS MAY BE REDUCED OR DENIED. CALL THE 1-800 NUMBER ON YOUR MEMBERSHIP ID CARD FOR PRIOR AUTHORIZATION. IN CASE OF AN EMERGENCY, YOU SHOULD SEEK IMMEDIATE CARE FROM THE CLOSEST HEALTH CARE PROVIDER.

BLUECARD

If You don't have BLUECARD PPO (Your membership card doesn't have the "PPO in a suitcase" logo), You can go to any BlueCard Participating Provider, and receive the same level of benefits.

BLUECARD WORLDWIDE

Through the BlueCard Worldwide Program, You also have access to a participating hospital network and referrals to doctors in major travel destinations throughout the world. When You need to locate a hospital or doctor, You can call the BlueCard Worldwide Service Center at 1.800.810.BLUE, or call collect at 1.804.673.1177, 24 hours a day, 7 days a week. You can also visit the web site ***https:/international.worldaccess.com/bcbsa/index.asp?page=login***, or You can call BCBST. When You need inpatient medical care, call the BlueCard Worldwide Service Center, who will refer You to a participating hospital. You will only be responsible for the Plan's usual out-of-pocket expense (i.e., non-covered expenses, deductible, copayment and/or coinsurance). In an emergency, You should go to the nearest hospital and call the BlueCard Worldwide Service Center if You are admitted. You still have the choice of using non-BlueCard Worldwide hospitals; however, You may have to pay the hospital directly and then file a claim for reimbursement. Your out-of-pocket expenses may be significantly higher. The BlueCard Worldwide Service Center will also provide referrals to doctors, but You will have to pay the provider and then file the claim for reimbursement.

SECTION III - COST CONTAINMENT FEATURES: WHAT THEY ARE/HOW TO USE THEM

WHAT YOU CAN DO TO CONTAIN COSTS

In order to take advantage of the cost-saving features of this program, it's important that You follow some basic procedures.

Before You receive health care services, You should be sure that Your health care provider is a Network Provider. Although You have received a directory listing the Network Providers in Your area, there may have been changes since printing.

PRIOR AUTHORIZATION

The purpose of Prior Authorization is to help ensure that patients receive services at the appropriate time and setting.

Prior Authorization may be required for certain services, including Advanced Radiological Imaging. Please have Your Physician contact BCBST at the telephone number shown on Your identification card before services are provided.

A PRIOR AUTHORIZATION confirmation is not a guarantee of benefits. Benefits are based on all terms and conditions of the ASA in force for the patient at the time services are provided.

Be sure to ask Your doctor to contact us to obtain Prior Authorization within 30 days before admitting You or a covered Dependent to a Hospital.

Your doctor must report Emergency Admissions to BCBST within 24 hours or within one working day after admission. PRIOR AUTHORIZATION is not required for maternity admissions.

Failure to follow the Prior Authorization procedure will result in benefits being reduced or denied.

CONCURRENT UTILIZATION REVIEW

The goal of Concurrent Utilization Review is to encourage the appropriate use of hospitalization.

BCBST monitors each case of hospitalization until the Physician discharges the patient. If a Physician determines that a patient needs to remain in the Hospital, additional certification should be requested.

If the review process determines Hospital care is no longer Medically Necessary we will notify Your Physician and the Hospital of the date on which benefits will end.

DURABLE MEDICAL EQUIPMENT

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

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. And, You also need to remember how the Cost Containment Features can affect Your benefits.

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 which 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. (Psychiatric services, for instance, usually have a specific benefit maximum.)

HOSPITAL AND OTHER FACILITY PROVIDER SERVICES

Inpatient Services

Room, board, and general nursing care in a

- semi-private room,
- private room (limited to most common semi-private room rate, unless approved by BCBST),
- Special Care Unit as approved by BCBST;
- 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; and
- Pre-admission testing.

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 "Emergency" or "Emergency Medical Condition" means the sudden onset of a medical condition of sufficient severity that, in the absence of immediate medical attention, could reasonably be expected to result in:

- serious impairments to body functions;
- serious dysfunction of a bodily organ or part; or
- placing the Member's health in serious jeopardy.

An "Emergency" does not include treatment of a chronic condition in which subacute symptoms have existed over a period of time

and would not be considered an Emergency unless symptoms suddenly became severe enough to require immediate medical assistance.

“Emergency Services” means health care services and supplies furnished in a Hospital which are required to determine, evaluate and/or treat an Emergency Medical Condition until such Condition is stabilized, as directed or ordered by a Physician or Hospital protocol.

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

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

Ambulance

Benefits are available for an Ambulance to transport the Member:

f. from a Member's home or the scene of an accident or medical Emergency to the nearest Hospital where appropriate medical or surgical services are available;

g. between Hospitals; and

h. between a Hospital and a Skilled Nursing Facility.

Benefits are available for air and water Ambulance only when ground Ambulance is not available or when justified by the patient's medical condition, as determined by BCBST.

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

Cardiac Rehabilitation Services

Subject to Pre-Treatment Certification Requirements, benefits will be available as stated in the Schedule of Benefits for Cardiac Rehabilitation Services, including:

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

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 BCBST Medical Necessity guidelines with regard to frequency and duration of exercise and education program.

Dental Care

Benefits are provided only for removal of impacted teeth or for dental work needed as a result of an Accidental Injury to the jaw, natural teeth, mouth, or face. To be covered, the accident must occur on or after the date the injured Member's coverage began.

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

Anesthesia for Dental Services

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

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

Diabetes Treatment

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

- prescribed and certified by a Physician as Medically Necessary; and

- provided by a Participating Physician, Registered Nurse, Dietitian, or Pharmacist who has completed a diabetes patient management program recognized by the American Council on Pharmaceutical Education and the Tennessee Board of Pharmacy.

Services and supplies included under this provision shall include:

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

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

Durable Medical Equipment and Supplies

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

Benefits are available for cranial hair prostheses (wigs) for hair loss resulting from chemotherapy, radiation, autoimmune and other clinical disease, subject to Deductible and Coinsurance and a $500 Lifetime Maximum.

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

Eyeglasses or Contact Lenses

- one set following cataract Surgery

Home Health Care

Benefits are available for the following services when prescribed by the Member's Physician and performed and billed by a Home Health Care Agency: part-time or intermittent nursing care by a visiting RN or LPN (not to include private duty nursing); physical therapy and respiratory therapy by persons licensed to perform such services; oxygen and its administration; and diagnostic services.

Hospice Home Care
(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, (or more frequently, based on the recommendation of the Member's Physician).

Office Visits for an Illness or Injury

Benefits will be available for an office visit in connection with an annual cervical cancer screening.

Organ Transplants

As soon as Your Provider tells You that You might need a transplant, You or Your Provider needs to contact Transplant Case Management.

Medically Necessary and Appropriate services and supplies provided to You, when You are the recipient of the following organan

transplant procedures: (1) heart; (2) heart/lung; (3) bone marrow; (4) lung; (5) liver; (6) pancreas; (7) pancreas/kidney; (8) kidney; (9) small bowel; and (10) small bowel/liver. Benefits may be available for other organ transplant procedures which, in Our sole discretion, are not Experimental or Investigational and which are Medically Necessary and Medically Appropriate.

You have access to three levels of benefits: In-Transplant Network, In-Network, and Out-of-Network. If You go to an In-Transplant Network Provider, You will have the highest level of benefits.

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

a. Prior Authorization Procedures

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

   Transplant Case Management is a mandatory program for those Members seeking transplant services. Call the 800 number on the front of Your ID card for customer service, and they can transfer You to Transplant Case Management. BCBST must be notified of the need for a transplant in order for it to be a Covered Service.

b. Covered Services

   The following Medically Necessary and Appropriate transplant services and supplies which have received Prior Authorization and are provided in connection with a Covered Procedure:

   - Medically Necessary and Appropriate services and supplies, otherwise Covered under this EOC.
   - Medically Necessary and Appropriate services and supplies for each listed organ transplant are Covered only when Transplant Case Management approves a transplant. Not all In-Network Providers are in Our Transplant Network. Please check with Transplant Case Management to see which Hospitals are in Our Transplant network.
   - Travel expenses for Your evaluation prior to a Covered Procedure, and to and from the site of a Covered Procedure by: (1) private car; (2) ground or air ambulance; or (3) public transportation. This includes Your and a companion's travel expenses. The companion must be Your Spouse, family member or Your guardian.
     - Travel by private car is limited to reimbursement at the IRS mileage rate in effect at the time of travel for travel more than 30 miles away from Your home to and from a facility in the Transplant Network.
     - Meals and lodging expenses are Covered if You or Your companion travels more than 30 miles each way, and are limited to $150 daily.
     - The aggregate limit for travel expenses is $10,000 per Covered Procedure and is included in Your Lifetime Benefit Maximum.
     - Travel Expenses are Covered only if You go to a Contracted Transplant Institution;
   - Donor Organ Procurement. If the donor is not a Member, Covered Services for the donor are limited to those services and supplies directly related to the transplant service itself: (1) testing for the donor's compatibility; (2) removal of the organ from donor's body; (3) preservation of the organ; and (4) transportation of the organ to the site of transplant. Services are Covered only to the extent not covered by other health coverage. The search process and securing the organ are also Covered under this benefit. Complications of donor organ procurement are not Covered. The cost of Donor Organ Procurement is included in the total cost of Your Organ Transplant.

c. Conditions/Limitations

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

- You or Your Physician must notify Transplant Case Management prior to Your receiving any transplant service, including pre-transplant evaluation, and obtain Prior Authorization. If Transplant Case Management is not notified, the transplant and related procedures will not be Covered at all;
- Transplant Case Management will coordinate all transplant services, including pre-transplant evaluation. You must cooperate with BCBST in coordination of these services;
- Failure to notify BCBST of proposed transplant services, or to coordinate all transplant related services with BCBST, will result in the reduction or exclusion of payment for those services;
- You must go through Transplant Case Management and receive Prior Authorization for Your transplant to be Covered;
- Once You have notified Transplant Case Management and received Prior Authorization, You may decide to have the transplant performed outside the Transplant Network. **However, Your benefits will be greatly limited, as described below. Only the Transplant Maximum Allowable Charge for the Service provided will be Covered.**

    i. In-Transplant Network transplants. You have the transplant performed at an In-Transplant Network Provider. You receive the highest level of reimbursement for Covered Services. The Plan will reimburse the In-Transplant Network Provider at the benefit level listed in the Schedule of Benefits, at the Transplant Maximum Allowable Charge. The In-Transplant Network Provider cannot bill You for any amount over the Transplant Maximum Allowable Charge for the transplant, which limits Your liability;

    ii. In-Network transplants. You have the transplant performed outside the Transplant Network, but still at a facility that is an In-Network Provider or a BlueCard PPO Participating Provider. The Plan will reimburse the In-Network or BlueCard PPO Participating Provider at the benefit levels listed in the Schedule of Benefits, limited to the Transplant Maximum Allowable Charge. There is no maximum to Your liability. The Provider also has the right to bill You for any amount not Covered by the Plan – this amount may be substantial;

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

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

- Kidney transplants. These are slightly different. There are two levels of benefits for kidneys: In-Network and Out-of-Network:

    i. In-Network kidney transplants. You have a kidney transplant performed at a facility that is an In-Network

Provider or a BlueCard PPO Participating Provider. You receive the highest level of reimbursement for Covered Services. The In-Network or BlueCard PPO Participating Provider cannot bill You for any amount over the Maximum Allowable Charge for the transplant, which limits Your liability;

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

If You go through Transplant Case Management for Your transplant, follow its procedures, cooperate fully with them, and have Your transplant performed at a Contracted Transplant Institution, the transplant expenses specified in the Schedule of Benefits are Covered, up to Your Lifetime Maximum.

d. Exclusions

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

- If You do not receive Prior Authorization, the transplant and related services will not be Covered;
- Any service specifically excluded from Coverage, except as otherwise provided in this section;
- Services or supplies not specified as Covered Services under this section;
- If You receive Prior Authorization through Transplant Case Management, but do not obtain services through the Transplant Network, You will have to pay the Provider any additional charges not Covered by the Plan;
- Any attempted Covered Procedure that was not performed, except where such failure is beyond Your control;
- Non-Covered Services;
- Services which are covered under any private or public research fund, regardless of whether You applied for or received amounts from such fund;
- Any non-human, artificial or mechanical organ;
- 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;
- Donor services including screening and assessment procedures which have not received Prior Authorization from Us;
- 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;
- Harvest, procurement, and storage of stem cells, whether obtained from peripheral blood, cord blood, or bone marrow when reinfusion is not scheduled within 3 months of harvest;
- Other non-organ transplants (e.g., cornea) are not Covered under this Section, but may be Covered as an Inpatient Hospital Service or Outpatient Facility Service, if Medically Necessary.

Outpatient Private Duty Nursing

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

Preventive Services

Benefits are available for Members for Medically Necessary and Appropriate

services for assessing physical status and detecting abnormalities. Covered Services include:

- Annual preventive health exam for adults and children age six and older, including screenings and counseling services with an A or B recommendation by the United States Preventive Services Task Force (USPSTF) and performed by the physician during the preventive health exam.
- Preventive health exam for children through age 5, including screenings with an A or B recommendation by the United States Preventive Services Task Force (USPSTF) and performed by the physician during the preventive health exam ("Well Child Care").
- Immunizations recommended by the Advisory Committee on Immunization Practices that have been adopted by the Centers for Disease Control and Prevention (CDC).
- Annual Well Woman Exam, including cervical cancer screening, screening mammography at age 40 and older, and other screenings with an A or B recommendation by the United States Preventive Services Task Force (USPSTF).
- Colorectal cancer screening (age 50-75).
- Prostate cancer screening for men age 50 and older.
- Screening and counseling in the primary care setting for alcohol misuse and tobacco use.
- Dietary counseling for adults with hyperlipidemia, hypertension, Type 2 diabetes, obesity, coronary artery disease and congestive heart failure.

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

- **aquatic therapy** – physical therapy performed in water.
- **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 InfusionTherapy** -- treatment which involves the continuous slow introduction of a solution into the body
- **Inpatient rehabilitation services –** a confinement primarily for rehabilitative services (these services are limited to 100 days per calendar year).
- **occupational therapy** -- treatment which involves the use of activities designed to restore, develop and/or maintain a person's ability to accomplish those daily living tasks necessary to a particular occupational role.
- **physical therapy** -- treatment to relieve pain, restore bodily function, and prevent disability following illness, injury, or loss of a body part
- **radiation therapy** -- treatment of disease by x-ray, radium, or radioactive isotopes
- **respiratory therapy** -- introduction of dry or moist gases into the lungs
- **speech therapy** -- treatment to restore or significantly improve a speech loss or impairment due to a congenital defect for which corrective Surgery has been performed, Accidental Injury, or disease other than a functional nervous disorder.

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.

PRE-EXISTING CONDITIONS LIMITATIONS

A Pre-existing Condition is a physical or mental condition (except for pregnancy), or any other condition which was present during the six months period before the Member's Enrollment Date under this plan, for which medical advice, diagnosis, care or treatment was recommended or received from a Provider of health care services.

No benefits will be paid for a Pre-existing Condition until 12 months from the Enrollment Date. This 12 month Pre-existing Waiting Period may be reduced by periods of Creditable Coverage provided there is no more than a 63 day break in coverage. Waiting periods required before coverage becomes effective will not count toward the 63 day break in coverage.

EXCLUSIONS

1. services or supplies not prescribed or performed by a Physician or Professional Other Provider, as defined in the Basic Terms Section
2. services or supplies which we determine are not Medically Necessary
3. services provided before the Member's coverage begins or during the Pre-Existing Waiting Period specified in the Schedule of Benefits
4. a drug, device, or medical treatment or procedure which is Experimental or Investigational (see Section VIII, Definition of Terms)
5. any work related illness or injury compensable under Workman's Compensation or On the Job Injury Program.
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 occurs while a Member under this Plan and results from:

    - disease;
    - birth defect;
    - Surgery (excluding non-functional scar revision); or
    - Accidental Injury.
11. self-treatment or services provided by any person related to the Member by blood or marriage, including the Member's spouse, parent, child, legal guardian, aunt, uncle, stepchild, or any person who resides in the Member's immediate household
12. services rendered by other than a Hospital, Physician or Other Provider(s) specified in this Plan
13. services paid under any other group, blanket or franchise insurance coverage;

any other Blue Cross or Blue Shield group ASA, other health insurance plan, union welfare plan, or labor-management trust plan

14. personal hygiene and convenience items (such as air conditioners, humidifiers, or physical fitness equipment)
15. telephone consultations, charges incurred due to failure to keep a scheduled appointment, or charges to complete a claim form or to provide medical records
16. Hospital admissions which are primarily for diagnostic studies
17. whole blood, blood components, and blood derivatives which are not officially classified as drugs
18. Custodial Care
19. routine foot care, or the treatment of flat feet, corns, bunions, calluses, toe nails, fallen arches, weak feet, and chronic footstrain
20. routine physical examinations, immunizations, and screening examinations including x-rays made without film, except as otherwise specified
21. Physician's charges for well-baby care, except as otherwise specified
22. services or supplies for dental care (except as specified in Section IV – Your Benefits) including, but not limited to: (1) crowns; (2) caps; (3) plates; (4) bridges; (5) dental x-rays; (6) fillings; (7) periodontal surgery; (8) prophylactic removal of non-impacted wisdom teeth; (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.
23. eyeglasses, contact lenses, and examinations for and the fitting of eyeglasses and contact lenses
24. hearing aids and examinations for and the fitting of hearing aids;

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

    (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 will be covered, subject to the Deductible and Coinsurance, but limited to 100 days per calendar year.)
27. Surgery to change sex, and related services
28. 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.
29. services covered under Medicare, except as required by applicable state or federal law
30. non-medical self-care or self-help training and any related diagnostic testing or medical social services
31. 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), except as otherwise specified

32. an artificial heart or any other artificial organ, or any associated expense
33. services or supplies for the reversal of sterilization
34. services or supplies incurred after a Concurrent Review determines the services and supplies are no longer Medically Necessary
35. charges in excess of the Maximum Allowable Charge for a service or supply
36. 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
37. 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
38. services or supplies in connection with treatment of obesity, except as otherwise noted
39. any charges for services and supplies rendered to a Member which require the Approval of BlueCross BlueShield of Tennessee, where such Approval is not given
40. services required as a result of the commission of a felony by the Member, or the attempt to commit a felony
41. services or supplies rendered prior to the Effective Date or after a Member's coverage is terminated, except as otherwise specified
42. room, board, and general nursing care rendered on the date of discharge, unless both admission and discharge occur on the same day
43. a second or third surgical opinion rendered by a Physician in the same medical group or practice as (a) the Physician who initially recommended the Surgery, or (b) the Physician who rendered either the second or third surgical opinion
44. staff consultations required by Hospital rules
45. prosthetic appliances or items of Durable Medical Equipment to replace those which were lost, damaged, or stolen or prescribed as a result of improved technology
46. exercise or athletic equipment, saunas, whirlpools, air conditioners, water purifiers, humidifiers, home modifications or improvements, motorized vehicles (except electric wheelchairs), swimming pools, tanning beds, and recreational equipment
47. dental appliances, including those used for correction of jaw malformations, except where prescribed as part of a surgical procedure necessary to restore a major bodily function
48. Inpatient private duty nursing in an acute care Hospital
49. over-the-counter drugs (not requiring a prescription), unless required by law or specifically designated as covered under this Plan; prescription devices, vitamins, except those which by law require a prescription; and/or prescription drugs dispensed in a doctor's office
50. for any care or treatment involving acupuncture
51. replacement of implanted cataract lenses
52. for court-ordered treatment of a Subscriber unless benefits are otherwise payable
53. medical treatment for which the Member has been reimbursed under a mass tort or class action lawsuit, settlement or judgment
54. abortion, unless the life of the mother is in danger

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.

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

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

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

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

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

A Network Provider, or a Non-Network Provider may refuse to render, or reduce or terminate a service that has been rendered, or require You to pay for what

You believe should be a Covered Service. If this occurs:

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

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

PAYMENT

If You received Covered Services from a Network Provider, We will pay the Network Provider directly. These payments are made according to Our agreement with that Network Provider. You authorize assignment of benefits to that Network Provider. Covered Services will be paid at the In-Network Benefit level.

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

a. Non-Contracted Providers may or may not file Your claims for You. Either way, the In-Network Benefit level shown in the Schedule of Benefits, will apply to claims for Covered Services received from Non-Contracted Providers. However, You will be responsible for the difference in the Billed Charge and the Maximum Allowable Charge for that Covered Service. Our payment fully discharges Our obligation related to that claim.

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

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

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

ASSIGNMENT

If You assign payment for a claim to a Provider, We must honor that assignment, in most circumstances. If You have paid the Provider, and also assigned payment for the claim to the Provider, You must request repayment from that Provider.

"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 Your nearest BCBST office:

Chattanooga 423-755-5917

Jackson	901-664-4100
Nashville	615-386-8500
Johnson City	423-854-6000
Knoxville	865-588-4600
Middle Tennessee	931-386-8500

Mail all claim forms to:

BCBST Claims Service Center
1 Cameron Hill Circle, Suite 0002
Chattanooga, TN 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

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

a. 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.

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

c. 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.

d. This Procedure incorporates the definitions of: (1) Adverse Benefit Determination; (2) urgent care; and (3) pre-service and post-service claims ("Claims"), that are in the Employee Retirement Income Security Act of 1974 ("ERISA"); Rules and Regulations for Administration and Enforcement; Claims Procedure (the "Claims Regulation").

   An Adverse Benefit Determination is any denial, reduction, termination or failure to provide or make payment for what You believe should be a Covered Service.

   - If a Provider does not render a service, or reduces or terminates a service that has been rendered, or requires You to pay for what You believe should be a Covered Service, You may submit a Claim to Us to obtain a determination concerning whether the Plan will cover that service. As an example, if a pharmacy does not provide You with a prescribed medication or requires You to pay for that prescription, You may submit a Claim to Us to obtain a determination about whether it is Covered by the Plan. Providers may be required to hold You harmless for the cost of services in some circumstances.

   - Providers may also appeal an Adverse Benefit Determination through Our Provider dispute resolution procedure.

   - A Plan determination will not be an Adverse Benefit Determination if: (1) a Provider is required to hold You harmless for the cost of services rendered; or (2) until a final Adverse Benefit Determination has been rendered in a matter being appealed through the Provider dispute resolution procedure.

e. You may request a form from the Plan to authorize another person to act on Your behalf concerning a Dispute.

f. 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.

g. 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

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.

First Level Grievance

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

Contact the customer service department at the number listed on Your membership ID card for assistance in preparing and submitting Your Grievance. They can provide You with the appropriate form to use in submitting a Grievance. This is the first level Grievance procedure and is mandatory. BCBST 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 statement of the committee's understanding of Your Grievance;
- The basis of the committee's decision; and
- Reference to the documentation or information upon which the committee based its decision. You may receive a copy of such documentation or information, without charge, upon written request.

Second Level Grievance

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

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

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

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

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.

Independent Review of Medical Necessity Determinations

If Your Grievance involves a Medical Necessity determination, then either: (1) after completion of the mandatory first level Grievance; or (2) after completion of the mandatory first level Grievance followed by completion of the second level Grievance, You may request that the Dispute be submitted to a neutral third party, selected by Us, to independently review and resolve such Dispute(s). If You request an independent review following the mandatory first level Grievance, You waive Your right to a second level Grievance and Your right to present oral testimony during the Grievance Process. Your request for

independent review must be submitted in writing within 180 days after the date You receive notice of the decision. Receipt shall be deemed to have occurred no more than two days after the date of issuance of the decision. Any person involved in making a decision concerning Your Dispute will not be a voting member of the independent review panel or committee.

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

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

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

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

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

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

SECTION VIII - RIGHTS OF RECOVERY AND REIMBURSEMENT

RIGHT OF RECOVERY.

If another party is legally responsible for causing a Member's illness or injury, BCBST has the right on behalf of the Employer to recover any amounts paid for any services required to treat such illness or injuries from: that party; his or her insurer; or any other source that is legally obligated to pay for such services, including uninsured or underinsured motorist coverage (collectively "Responsible Parties"), whether or not the Member has been made whole by such Responsible Parties pursuant to the ASA.

A Member shall be deemed to have granted such right of recovery to BCBST individually and on behalf of his or her representatives, heirs, successors, or assigns as a condition of receiving Covered Services from BCBST.

SUBROGATION

In addition to the Right of Recovery under section A, above, if another party is legally responsible for causing a Member's illness or injury, that Member shall be deemed to assign, transfer and subrogate all of his or her rights of action against any Responsible Parties to the Employer and to BCBST, to the full extent benefit payments were made for Covered Services provided to treat such illness or injury, plus the costs of recovering such amounts from those Responsible Parties, whether or not the Member has been made whole by such Parties. Such actions may be based in tort, contract or other cause of action, to the fullest extent permitted by law.

LIEN

Employer and BCBST shall have a lien against any payment judgment or settlement of any kind that a Member receives from or on behalf of Responsible Parties for the cost of providing services to that Member and any costs of recovering such amounts from Responsible Parties, whether or not the Member is made whole by that recovery. Employer or BCBST may notify other parties of its lien without notice to, or the consent of, that Member.

The recovery and subrogation rights stated in this provision shall be considered to be a first priority claim against the proceeds of any judgment against, settlement with, or payment from Responsible Parties; to be paid before any other claims are paid, whether or not the Member has recovered the total amount of his or her damages. In the event the Member settles any claim or action against any third party, the Employer or BCBST shall be entitled to immediately collect the present value of its claims pursuant to this section as the first priority claim from the settlement fund. Any such proceeds of settlement or judgment shall be held in trust by the Member for the benefit of Employer.

NOTICE AND COOPERATION.

Members must promptly notify the Claims Administrator if they are injured or become ill as a result of the act or omission of other parties, to enable the Plan to protect its rights pursuant to this section. Members must cooperate with the Plan and agree to execute any documents that Employer or Claims Administrator deem necessary to protect the rights of the Employer under this section. The Member is solely responsible for paying all costs of litigation, including any attorney fees and expenses, regarding any proceeds obtained from any judgment against, settlement with, or payment from Responsible Parties. The Plan will not pay the attorney fees for the Member's attorney.

SECTION IX - TERMINATION OF MEMBER COVERAGE

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

- Coverage will terminate on the last date for which payment was made if:
  - the required contribution is not paid, or
  - such person ceases to meet the eligibility requirements specified in the Schedule of Eligibility.
- If You elect continuation coverage as specified in a following paragraph You must pay to the Employer monthly contribution for such coverage. Initial contribution for continuation coverage will be due no later than 45 days after the date continuation coverage is elected. Employer will in turn remit to us such contribution with payment of our regular billing.
- Dependent coverage will terminate on the last day of the month the Dependent no longer meets the definition of eligible Dependent.
- Members otherwise eligible for coverage under this plan as an Employee or the spouse of an active Employee may continue benefits under Federal laws regarding the Working Aged (P.0.L. 97-248, as amended).
- All coverage provided under this plan will end on the last day of the month in which termination occurred. No benefits will be provided for any service or supply rendered on or after such date.
- If a Member does not follow program guidelines, including paying required Copayments or Coinsurance to Participating Providers, BCBST, in its sole discretion, has the right to cancel a Member's coverage with 30 days notice, subject to the Member's grievance rights.

CONTINUATION COVERAGE

Your Employer may be required under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or State law to offer continuation coverage for benefits available under this plan after the date such coverage would otherwise end.

d. As Plan Administrator, Your Employer will be responsible for providing notice of Member rights and application of these rights to particular circumstances.

e. Any Member who does not elect, or discontinues, available continuation coverage must satisfy all of the then applicable eligibility and underwriting requirements at the time a new application for this coverage is made.

LEAVE OF ABSENCE

Notwithstanding other provisions of this Section, continuous coverage during a leave of absence is permitted for up to 24 months if:

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

BENEFITS AFTER COVERAGE ENDS

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

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

SECTION X - DEFINITION OF TERMS

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

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

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

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

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

Benefit Period- a calendar year during which this plan is in force during which benefits for Covered Services may be available. Charges for Covered Services are considered incurred on the date they are provided.

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

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 *S*ervice Area with whom that organization does not have an agreement.

Blue Preferred Provider (Network Provider) - a Physician, Hospital, or other Provider that has contracted with BCBST to furnish services and to accept BCBST's payment, plus applicable Deductibles and Copayments, as payment in full for Covered Services.

Case 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. Case 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 Benefit Period 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 non-Participating 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 non-Participating Provider's Billed Charges may exceed the Coinsurance Payment percentage set forth in the Schedule of Benefits.

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

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

If, under such review, it is determined that continued care is not Medically Necessary,

the facility and Physician will be notified in writing of a specific date after which benefits will no longer be payable under this plan. The Member or Physician can appeal the decision by contacting us. The case will be reviewed and both the Physician and the Member will be notified of the results.

Contracted Transplant Network Institution -- is one which has contracted with the administrator (or with an entity on behalf of the administrator) to provide facility Transplant Services for the organ and bone marrow transplant procedures Covered under this EOC. (A list of Contracted Transplant Institutions is available from BCBST upon request by the Employer or the Member.)

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

Copayments do not apply toward satisfying Deductibles, Out-of-Pocket, or lifetime maximums.

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

Creditable Coverage - individual or group health coverage of the Member prior to his or her Enrollment Date which may be applied to reduce a Member's Pre-existing Condition Waiting Period, if any, stated in this plan. Creditable Coverage also includes coverage under COBRA, a health maintenance organization, Medicare, Medicaid (including TennCare), the Federal Employee Health Benefit Plan, and/or a public, government, military or Indian Health Service benefit program.

Up to 18 months of Creditable Coverage may be applied to reduce the Member's applicable Pre-existing Condition Waiting Period. However, a period of coverage will not be counted for purposes of reducing a Member's Pre-existing Condition Waiting Period if there is a break in such coverage of 63 days or more during which the Member was not covered under any Creditable Coverage.

Custodial Care - any services or supplies provided to assist an individual in the activities of daily living, such as help in walking, getting in or out of bed, or any service that could be performed by a family member or non-professional personnel.

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

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

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

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

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 which:

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

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

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

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

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

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

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

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

Emergency - the sudden onset of a medical condition of sufficient severity which, in the absence of immediate medical attention, could result in:

- permanently placing a Member's health in jeopardy;
- causing other serious medical consequences;
- causing serious impairments to body functions; or
- causing serious or permanent dysfunction of any body organ or part

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

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

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

Experimental or Investigational Services - a drug, device, treatment, therapy, procedure, or other service or supply that does not meet the definition of Medical Necessity or:

- cannot be lawfully marketed without the approval of the Food and Drug Administration ("FDA") when such approval has not been granted at that time of its use or proposed use, or

- is the subject of a current Investigational new drug or new device application on file with the FDA, or
- is being provided according to Phase I or Phase II clinical trial or the Experimental or research portion of a Phase III clinical trial (provided, however, that participation in a clinical trial shall not be the sole basis for denial), or
- is being provided according to a written protocol which describes among its objectives, determining the safety, toxicity, efficacy or effectiveness of that service or supply in comparison with convention alternatives, or
- is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board ("IRB") as required and defined by Federal regulations, particularly those of the FDA or the Department of Health and Human Services ("HHS"), or
- The Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research within HHS has determined that the service or supply is either Experimental or Investigational or that there is insufficient data to determine if it is clinically acceptable, or
- in the predominant opinion of experts, as expressed in the published authoritative literature, that usage should be substantially confined to research settings, or
- in the predominant opinion of experts, as expressed in the published authoritative literature, further research is necessary in order to define safety, toxicity, efficacy, or effectiveness of that Service compared with conventional alternatives, or
- the service or supply is required to treat a complication of an Experimental or Investigational Service.

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

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

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

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

Freestanding Dialysis Facility - a facility Other Provider which 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.

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.

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

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

In-Transplant Network – A network of Hospitals and facilities, each of which has agreed to perform specific organ transplants. For example, some Hospitals might contract to perform heart transplant, but not liver transplants.

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

Late Enrollee - an Employee or eligible Dependent who did not apply, or for whom application was not made, for coverage within 31 days after such person first became eligible for coverage under this plan.

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

Maximum Allowable Charge - The amount that the Plan, at its sole discretion, has determined to be the maximum amount payable for a Covered Service. That determination will be based upon the Plan's contract with a Network Provider or the amount payable based on the administrator's fee schedule for the Covered Services.

Maximum Lifetime Amount - the total dollar amount of benefits available under this plan during the Member's lifetime, as stated in the Schedule of Benefits.

The lifetime amount (as stated in the Schedule of Benefits) will be subject to (and

reduced by) amounts paid in any and all contract years preceding the Effective Date of this coverage, provided the Member has had continuous coverage under group health contract(s) between BCBST and employer during such years.

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 which have been determined by the Medical Director of the Plan to be of value in the care of a specific Member. To be Medically Appropriate a service must:

- be Medically Necessary.
- be used to diagnose or treat a Member's condition caused by disease, injury or congenital malformation.
- be consistent with current standards of good 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.
- on an ongoing basis, have a reasonable probability of:
  - correcting a significant congenital malformation or disfigurement caused by disease or injury.
  - preventing significant malformation or disease.
  - substantially improving a life sustaining bodily function impaired by disease or injury.
- not be provided solely to improve a Member's condition beyond normal variations in individual development and aging including:
  - comfort measures in the absence of disease or injury.
  - improving physical appearance that is within normal individual variation.
- not be for the sole convenience of the Provider, Member or Member's family.

Medically Necessary or Medical Necessity – services which have been determined by the Plan to be of proven value for use in the general population. To be Medically Necessary a service must:

- have final approval from the appropriate government regulatory bodies.
- have scientific evidence permitting conclusions concerning the effect of the service on health outcomes.
- improve the net health outcome.
- be as beneficial as any established alternative.
- demonstrate the improvement outside the investigational setting.
- not be an Experimental or Investigational service.

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

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.

Non-Participating Pharmacy - means a pharmacy other than a Participating Pharmacy.

Non-Participating Provider - a Physician, Hospital, or Other Provider that has not contracted with BCBST to furnish services and to accept BCBST's payment, plus applicable Deductibles and Copayments, as payment in full for Covered Services.

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

- suppliers of Durable Medical Equipment, appliances, and prosthesis;
- suppliers of oxygen;
- certified Ambulance service;
- Hospice;

- Pharmacy;
- Freestanding Diagnostic Laboratory;
- Home Health Care Agency; and/or
- freestanding and mobile diagnostic or physical therapy facility.

Out-of-Pocket Maximum - means the dollar amount stated in the Schedule of Benefits for which a Member is responsible for Covered Services during a Benefit Period. This maximum can be satisfied by a combination of charges for Covered Services from Network or Non-Network Provider's eligible charges, including the Deductible; however, this does not include Psychiatric Care or 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 Benefit Period. However, the Non-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 Benefit Period.

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

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

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

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

Participating 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 BCBST (or entity contracting with BCBST) to provide those health care services to Members under this plan. A Participating Provider may bill or seek reimbursement for Authorized Services from BCBST, except for the Member's Deductibles, Copayments, or Coinsurance amounts.

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.

Pre-existing Condition - any physical or mental condition, excepting pregnancy, or any other condition which was present during the six months period before the Member's Enrollment Date under this plan, for which medical advice, diagnosis, care or treatment was recommended or received from a Provider of health care services.

Genetic information will not be considered as a Pre-existing Condition unless there is a diagnosis of a condition related to such information.

Pre-existing Condition Waiting Period - the period stated in the Schedule of Benefits of not more than 12 months which begins on the Member's Enrollment Date and during which benefits are not available for services received in connection with a Pre-existing Condition.

The Pre-existing Condition Waiting Period will be reduced by the periods(s) of Creditable Coverage occurring within 18 months before the Enrollment Date (provided there is no break of 63 days or more during which the Member was not covered under any Creditable Coverage).

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

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

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 Participating 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.

Transplant Maximum Allowable Charge (TMAC) – The amount that the Plan, at its sole discretion, has determined to be the maximum amount payable for Organ Transplants. Each type of Organ Transplant has a separate TMAC. That determination will be based upon the contract with a Transplant Network Provider or the amount payable based on the fee schedule for the Covered Services rendered by Out-of-Network Providers.

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

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

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

IMPORTANT NOTICE FOR MASTECTOMY PATIENTS

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

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

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

UNIFORM 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 Uniform 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

The Subscriber Number shown on my identification card is:

The "Effective Date" when my coverage begins is:

® Registered marks of the BlueCross BlueShield Association, an Association of Independent BlueCross BlueShield Plans

Printed
B/BPM.7/02