BlueCross BlueShield of Tennessee

Evidence of Coverage

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

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

Customer Service Department
BlueCross BlueShield of Tennessee
1 Cameron Hill Circle
Chattanooga, Tennessee 37402-0002
1-(800) 565-9140

ATTENTION: If you speak English, free language assistance services and appropriate auxiliary aids and services are available to you. Please call the Member Service number on the back of your Member ID card or 1-800-565-9140 (TTY: 1-800-848-0298).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma, así como ayudas y servicios auxiliares adecuados. Llame al número de Servicio de atención a miembros que figura en el reverso de su tarjeta de identificación de miembro o al 1-800-565-9140 (TTY: 1-800-848-0298).

انتباه: إذا كنت تتحدث العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية والخدمات والأدوات المساعدة المناسبة. يُرجى الاتصال برقم خدمة الأعضاء الموجود على ظهر بطاقة هوية العضو الخاص بك أو بالرقم 1-800-565-9140 (الهاتف النصي: 1-800-848-0298)

注意：如果您說中文，我們提供免費的語言協助服務，以及適當的輔助協助和服務。請撥打會員 ID 卡背面的會員服務部號碼或 1-800-565-9140（聽障專線 (TTY)：1-800-848-0298）。

LƯU Ý: Nếu quý vị nói tiếng Việt, quý vị sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí và các dịch vụ và công cụ hỗ trợ phù hợp. Vui lòng gọi đến số của bộ phận Dịch vụ Hội viên ở mặt sau Thẻ ID Thành viên của quý vị hoặc số 1-800-565-9140 (TTY: 1-800-848-0298).

주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스 및 적절한 보조 기구와 서비스가 제공됩니다. 가입자 ID 카드 뒷면의 가입자 서비스 전화번호 또는 1-800-565-9140 (TTY: 1-800-848-0298)번으로 전화하시기 바랍니다.

ATTENTION : Si vous parlez français, des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés sont à votre disposition. Veuillez appeler le numéro du Service adhérents indiqué au dos de votre carte d'assuré adhérent ou le 1-800-565-9140 (TTY/ATS : 1-800-848-0298).

ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາ ພາສາລາວ, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການທີ່ເໝາະສົມໃຫ້ທ່ານ. ກະລຸນາໂທຫາເບີຂອງຝ່າຍບໍລິການສະມາຊິກທີ່ມີຢູ່ດ້ານຫຼັງບັດ ID ສະມາຊິກຂອງທ່ານ ຫຼື 1-800-565-9140 (TTY: 1-800-848-0298).

ማስገንዘቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ረዳት መርጃዎች እና አገልግሎቶች ለእርስዎ ይገኛሉ። በአባልነት መታወቂያዎ ጀርባ ላይ በሚገኘው የአባላት አገልግሎት ቁጥር ወይም በ 1-800-565-9140 (TTY: 1-800-848-0298) ይደውሉ።

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste und geeignete Hilfsmittel und Dienstleistungen zur Verfügung. Bitte rufen Sie die Nummer des Mitgliederdienstes auf der Rückseite Ihrer Mitglieds-ID-Karte oder 1-800-565-9140 (TTY: 1-800-848-0298) an.

ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારા માટે નિઃશુલ્ક ભાષા સહાય સેવાઓ અને યોગ્ય સહાયક સાધનો અને સેવાઓ ઉપલબ્ધ છે. કૃપા કરીને તમારા સભ્ય ID કાર્ડની પાછળના સભ્ય સર્વિસ નંબર ઉપર અથવા 1-800-565-9140 (TTY: 1-800-848-0298) પર કૉલ કરો.

お知らせ：日本語をお話しになる場合は、無料の支援サービスと適切な補助器具・サービスがご利用いただけます。会員IDカードの裏面に記載の会員サービス番号あるいは1-800-565-9140 (TTY: 1-800-848-0298)まで、お電話にてご連絡ください。

PANSININ: Kung kayo ay nagsasalita ng Tagalog, magagamit para sa inyo ang libreng mga serbisyong tulong sa wika at kaukulang mga karagdagang tulong at mga serbisyo. Mangyaring tawagan ang numero ng Serbisyo sa Miyembro na nasa likod ng inyong Kard ng ID ng Miyembro o sa 1-800-565-9140 (TTY: 1-800-848-0298).

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएँ और उपयुक्त सहायक साधन और सेवाएँ उपलब्ध हैं। कृपया अपने सदस्य ID कार्ड के पीछे दिए गए सदस्य सेवा नंबर या 1-800-565-9140 (TTY: 1-800-848-0298) पर कॉल करें।

ВНИМАНИЕ! Если Вы говорите по-русски, Вам будут предоставлены услуги языковой поддержки и соответствующие вспомогательные средства и сервисы на бесплатной основе. Позвоните в отдел обслуживания участников по номеру, указанному на обратной стороне Вашей идентификационной карты участника, или по номеру 1-800-565-9140 (TTY: 1-800-848-0298).

توجه: اگر به زبان فارسی صحبت می کنید، خدمات کمک زبانی رایگان و مساعدت ها و خدمات کمکی مناسب در دسترس شما هستند. درصورتیکه عضو هستید، با شماره خدمات اعضا در پشت کارت عضویت خود یا 1-800-565-9140 (TTY: 1-800-848-0298) تماس بگیرید.

ATANSYON: Si w pale Kreyòl Ayisyen, genyen sèvis asistans gratis pou lang ansanm ak èd pou sèvis oksilyè apwopriye k ap disponib pou ou. Tanpri rele nimewo Sèvis Manm ki sou do kat ID Manm ou an oswa 1-800-565-9140 (TTY: 1-800-848-0298).

UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej oraz rozwiązań i usług pomocniczych. Prosimy zadzwonić pod numer działu obsługi ubezpieczonych podany na odwrocie karty identyfikacyjnej członka lub numer 1-800-565-9140 (TTY: 1-800-848-0298).

ATENÇÃO: Se você fala Português, serviços gratuitos de assistência linguística e recursos e serviços auxiliares apropriados estão disponíveis para você. Ligue para o número de telefone do serviço de Atendimento ao Membro informado no verso de seu cartão de identificação de membro ou para 1-800-565-9140 (TTY: 1-800-848-0298).

ATTENZIONE: se parla italiano, sono disponibili per Lei servizi gratuiti di assistenza linguistica nonché aiuti e servizi ausiliari adeguati. Chiami il numero del Servizio per i membri riportato sul retro della Sua scheda identificativa del membro oppure il numero 1-800-565-9140 (TTY: 1-800-848-0298).

BAA'áKOHWIINIDZIN: Diné bizaad bee yáníłti'go, t'áá jiik'eh saad bee áka'aná'awo' bee áka'anída'awo'í dóó t'áadoole'é binahjį' bee adahodooníłígíí diné bich'į' anídahazt'i'í bee bika'aanída'awo'í ná dahółǫ́. T'áá shóódí Bił Ha'dít'éhí Bika'aná'awo' Bił Ha'dít'éhí ID naaltsoos nitł'izí bine'dę́ę́' binámboo bee hodíilnih doodago 1-800-565-9140 (TTY: 1-800-848-0298).

WICHDICH: Wann du Deitsch schwetzscht un brauchscht Hilf fer communicat-e kenne mer dich helfe unni as es dich ennich eppes koschde zellt. Mir kenne differnti Sadde Schprooch-Hilf beigriege aa fer nix. Ruf der Member Service Number uff die hinnerscht Seit vun dei Member ID Card uff odder 1-800-565-9140 (TTY: 1-800-848-0298).

FAASILASILAGA: Afai e te tautala i le faa-Samoa, o loo avanoa mo oe auaunaga fesoasoani mo gagana e aunoa ma se totogi faapea ma fesoasoani fa'aopo'opo ma auaunaga talafeagai. Faamolemole vala'au le numera o le Member Service (Auaunaga mo Tagata Auai) o lo'o i tua o lau pepa ID o le Member (Tagata Auai) po o le 1-800-565-9140 (TTY: 1-800-848-0298).

GAKIULA: Gare iga go kapetal Faluwasch, ye toore paliuwal yamem bwe tepangug rel gamatefal lane kapetal Faluwasch. Fale peshem kol yegili nampal Member Service ila yelog liugul tagurul Member ID kard la yam gare 1-800-565-9140 (TTY: 1-800-848-0298).

ATENSION: Guaha setbisio siha para hågu yanggen fifino' CHamoru hao, dibåtde na setbision inayudon fumino' CHamoru yan propriu na inasisten tråstes yan setbisio siha. Put fabot ågang i numiron Setbision Membro gi santatten i kattå-mu Member ID pat 1-800-565-9140 (TTY: 1-800-848-0298).

Table of Contents

Get the Most from Your Benefits 1

Enrolling in the Plan 5

When Coverage Begins 8

When Coverage Ends 10

Continuation of Coverage 12

Prior Authorization, Care Management, Medical Policy and Patient Safety 16

Health and Wellness 20

Inter-Plan Arrangements 23

Claims and Payment.....26

Coordination of Benefits.....29

Grievance Procedure 35

Statement of ERISA Rights 40

Notice of Privacy Practices.....42

General Legal Provisions.....47

Definitions.....52

Attachment A: Covered Services and Exclusions.....66

Attachment B: Other Exclusions 100

Attachment C: Schedule of Benefits 103

Attachment D: Eligibility .....

Get the Most from Your Benefits

1. **Create Your online account and download the BCBSTN mobile app.** Go to bcbst.com/activate and click **register online account** so You can see and share Your Member ID card with a single tap, claims and access information about Your benefits anywhere, anytime. You can also download the BCBSTN mobile app from the App Store® or Google Play® and log in using the same password.[i]

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

   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 Us. Other Covered Services are limited.

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

   The Group has delegated discretionary authority to the Plan to make any benefit determinations. It has also granted the authority to construe the terms of Your Coverage with the Plan. The Plan shall be deemed to have properly exercised that authority unless it abuses its discretion when making such determinations, whether or not the Group's benefit plan is subject to ERISA. "ERISA" means the Employee Retirement Income Security Act. The Group retains the authority to determine whether You or Your Covered Dependents are eligible for Coverage.

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

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

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

   Your PPO plan has two levels of benefits. By using Network Providers, You receive the highest level of benefits. However, You can choose to use Providers that are not Network Providers. These Providers are called Out-of-Network Providers. When You use Out-of-

Network Providers, Your benefits may be lower. You may also be responsible for amounts that an Out-of-Network Provider bills above Our Maximum Allowable Charge and any amounts not Covered by Your Plan.

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

a. Emergency Care Services rendered at an out-of-network hospital Emergency department or a licensed freestanding Emergency department.
b. Covered items and services rendered by an Out-of-Network Provider at an in-network facility. In compliance applicable with state or federal law, You may agree to receive treatment for certain services from an Out-of-Network Provider and waive balance billing protections, provided that You provide consent prior to treatment, and that Your consent satisfies applicable regulatory requirements.
c. Emergent and other Authorized air ambulance services (the same criteria to determine if services from an in-network air ambulance Provider are Covered is used to determine whether services from an out-of-network air ambulance Provider are Covered).

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

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

By using Network Providers, You maximize Your benefits and avoid balance billing. Balance billing may occur when You use an Out-of-Network Provider and You may be billed for any unpaid Billed Charges. This amount can be substantial.

4. **Your BlueCross BlueShield of Tennessee Identification Card.** Once Your Coverage becomes effective, You will receive a BlueCross BlueShield of Tennessee Member identification (ID) card. Doctors and hospitals nationwide recognize it. **The Member ID card is the key to receiving the benefits of the health plan. Carry it at all times. Please be sure to show the Member ID card each time You receive medical services, especially whenever a Provider recommends hospitalization.**

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

Authorization, Care Management, Medical Policy and Patient Safety" section for more information.

If Your Member ID card is lost or stolen, or another card is needed for a Covered Dependent not living with You, please visit bcbst.com/myID or call the number listed on the front page of this EOC. You may want to record Your Member ID number for safekeeping.

5. **Always use Network Providers,** including Pharmacies, durable medical equipment suppliers, skilled nursing facilities and home infusion therapy Providers. See "Attachment A: Covered Services and Exclusions" for an explanation of a Network Provider. Call Our consumer advisors to verify that a Provider is a Network Provider or visit bcbst.com/Findaprovider or use the BCBSTN mobile app.

   If Your doctor refers You to another doctor, hospital or other health care Provider, or You see a covering physician in Your doctor's practice, please make sure that the Provider is a Network Provider. When using Out-of-Network Providers, You may be responsible for any unpaid Billed Charges. This amount can be substantial.

6. **Ask Our consumer advisors** if the Provider is in the specific network shown on Your Member ID card. Since BlueCross has several networks, a Provider may be in one BlueCross network, but not in all of Our networks. Visit bcbst.com/Findaprovider or use the BCBSTN mobile app for more information on Providers in each network.

7. **Primary Care Practitioner Program:** We encourage You to select and develop a relationship with an in-network Primary Care Practitioner (PCP). There are several advantages to selecting a PCP.

   a. PCPs are trained to provide a broad range of medical care and can be a valuable resource to coordinate Your overall health care needs.

   b. Developing and continuing a relationship with a PCP allows the Practitioner to become knowledgeable about You and Your family's health history.

   c. A PCP can help You determine when You need to visit a specialist and also help You find one based on their knowledge of You and Your specific health care needs.

   d. Care rendered by PCPs usually results in lower cost share for You.

   e. We will check Our records periodically to see if You have visited a PCP. If not, We may provide Your name and contact information to an in-network PCP who will call You and offer to schedule a wellness visit. The program is completely voluntary and although We encourage You to schedule this visit, You are not obligated to do so. The applicable PCP cost share will apply to this visit.

8. **Prior Authorization is required for certain services.** Reference the "Prior Authorization, Care Management, Medical Policy and Patient Safety" section for a partial list. Make sure Your Provider obtains Prior Authorization before any planned hospital stays (except maternity, initial admission only, and Emergency admissions), skilled nursing and rehabilitative facility admissions, certain outpatient procedures, certain Advanced

Radiological Imaging services, and before ordering certain Specialty Drugs and certain durable medical equipment. Call Our consumer advisors to find out which services require Prior Authorization. You can also call Our consumer advisors to find out if Your admission or other service has received Prior Authorization.

9. **To save money** when getting a Prescription filled, **ask if a generic equivalent is available**. You may be charged a Penalty if You choose a Preferred Brand Drug or Non-Preferred Brand Drug when a Generic Drug equivalent is available.
10. In a true Emergency it is appropriate to go to an Emergency room **(see Emergency definition in the "Definitions" section of this EOC). However, most conditions are not Emergencies and are best handled with a call to Your doctor's office.**
11. Ask that Your Provider **report any Emergency admissions to BlueCross within two (2) business days** from inpatient admission.
12. **Get a second opinion** before undergoing elective Surgery.
13. **If You need assistance with symptom assessment,** short-term care decisions, or any health-related question or concern, connect with a nurse by calling Our 24/7 Nurseline at 1-(800) 818-8581 or for hearing impaired, TTY 1-(888)-308-7231. The nurses can also assist with decision support and advice when contemplating Surgery, considering treatment options and making major health decisions.
14. **Notify** Your Employer within 31 days of a qualifying event if changes in the following occur for You or any of Your Covered Dependents:
    a. Name;
    b. Address;
    c. Telephone number;
    d. Employment (change companies or terminate employment);
    e. Status of any other health insurance You might have;
    f. Birth of additional dependents;
    g. Marriage or divorce;
    h. Death; or
    i. Adoption.

[i] *The App Store is a registered trademark of Apple, Inc.*

Google Play is a trademark of Google, Inc.

Enrolling in the Plan

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

A. Initial Enrollment Period

Eligible Employees may enroll for Coverage for themselves and their eligible dependents within the first 31 days after becoming eligible for Coverage. The Employee must (1) include all requested information; (2) sign; and (3) submit an Enrollment Form to the Plan during that initial enrollment period, except as otherwise indicated in paragraph D. below.

B. Open Enrollment Period

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

C. Special Enrollment Periods

You may enroll or change enrollment in Coverage outside of annual Open Enrollment Periods, based on an occurrence of one of the following triggering events:

1. You or Your dependent loses Minimum Essential Coverage;
2. You gain a dependent or become a dependent through marriage, birth, adoption, placement for adoption, placement for foster care or court order;
3. You experience enrollment or non-enrollment in Coverage that is unintentional, inadvertent, or erroneous and is the result of an error, misrepresentation, or inaction of an officer or employee;
4. You or Your dependent gains access to new Coverage as a result of a permanent move.

You or Your dependent has thirty (30) days from the date of a triggering event, unless specifically stated otherwise, to enroll or change enrollment in Coverage.

D. Adding Dependents

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

1. A newborn child of the Subscriber or the Subscriber's spouse is Covered from the moment of birth. A legally adopted child, including children placed with You for the purposes of adoption, will be Covered as of the date of adoption or placement for

adoption, whichever is first. Children for whom the Subscriber or the Subscriber's spouse has been appointed legal guardian by a court of competent jurisdiction, will be Covered from the moment the child is placed in the Subscriber's physical custody. The Subscriber must enroll the child within 31 days from the date that the Subscriber or the Subscriber's spouse acquires the child.

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

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

2. Any other new dependent (e.g. if the Subscriber marries) may be added as a Covered Dependent if the Subscriber completes and submits a signed Enrollment Form to the Group representative within 31 days of the date that person first becomes eligible for Coverage.

E. Late Enrollment

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

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

F. Enrollment Upon Change in Status

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

1. The Subscriber must request the change within 31 days of the change in status for the following events:
   a. Marriage or divorce;
   b. Death of the Employee's spouse or dependent;
   c. Change in dependency status;
   d. Medicare eligibility;
   e. Coverage by another Payor;
   f. Birth or adoption of a child of the Employee;

g. Termination of employment, or commencement of employment, of the Employee's spouse; or

h. Switching from part-time to full-time, or from full-time to part-time status by the Employee or the Employee's spouse.

2. The Subscriber must request the change within sixty (60) days of the change in status for the following events:

   a. Loss of eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage; or
   b. Becoming eligible to receive a subsidy for Medicaid or CHIP coverage.

3. An Employee or eligible dependent who did not apply for Coverage within 31 days of first becoming eligible for Coverage under this Plan may enroll if:

   a. He or she had other health care coverage at the time Coverage under this Plan was previously offered; and

   b. He or she stated, in writing, that such other coverage was the reason for declining Coverage under this Plan at the time Coverage under this Plan was previously offered; and

   c. Such other coverage is:

      i. COBRA and the COBRA coverage is exhausted; or

      ii. Non-COBRA and

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

         2. Employer contributions for the other coverage ended; and

   d. He or she applies for Coverage under this Plan and the administrator receives the change form within 31 days after the loss of the other coverage.

When Coverage Begins

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

A. Effective Date of Group Agreement

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

B. Special Enrollment Periods

Outside the annual Open Enrollment Period, You may enroll in or change plans if You experience an event that makes You eligible for a special enrollment period (SEP) as established by federal law. Your Coverage Effective Date may vary depending on the SEP for which You qualify. Special enrollment periods include, but are not limited to, loss of Minimum Essential Coverage, permanent move resulting in access to new coverage, and gaining or becoming a dependent due to marriage, birth, adoption, placement for adoption, placement for foster care or court order. See the "Enrolling in the Plan" section for additional information about requirements related to SEPs.

C. Enrollment During an Open Enrollment Period

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

D. Enrollment During an Initial Enrollment Period

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

E. Newly Eligible Employees

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

F. Newly Eligible Dependents

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

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

G. Actively at Work Rule

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

When Coverage Ends

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

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

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

B. Termination of Coverage Due to Loss of Eligibility

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

C. Termination or Rescission of Coverage

The Plan may terminate Your Coverage, if:

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

The Plan may terminate or Rescind Coverage, at its discretion, if You or Your Covered Dependent(s) have made an intentional misrepresentation of a material fact or committed fraud in connection with Coverage. If the misrepresentation or fraud occurred before Coverage became effective, the Plan may Rescind Coverage as of the Effective Date. If the misrepresentation or fraud occurred after Coverage became effective, the Plan may Rescind Coverage as of the date misrepresentation or fraud first occurred. If the Plan decides to Rescind Coverage, and if applicable, the Plan will return all Premiums paid after the termination date less any claims paid after that date. If claims paid after the termination date are more than Premiums paid after that date, the Plan has the right to collect that

amount from You to the extent allowed by law. We will notify You before the date of any Rescission in compliance with state or federal law.

D. Right to Request a Hearing

You may request that We conduct a Grievance hearing to appeal the termination of Your membership or Rescission of Your Coverage, as explained in the "Grievance Procedure" section. The fact that You have requested a hearing does not postpone or prevent the Plan from terminating Your Coverage. If Your Coverage is reinstated following that hearing, You may submit any claims for Covered Services rendered after Your Coverage was terminated to the Plan for consideration, in accordance with the "Claims and Payment" section.

E. Payment For Services Rendered After Termination of Coverage

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

F. Extended Benefits

If a Member is hospitalized on the date the Group Agreement is terminated, benefits for Hospital Services will be provided (1) for sixty (60) days; (2) until the Member is covered under another Plan; or (3) until the Member is discharged, whichever occurs first. The provisions of this paragraph will not apply to a newborn child of a Subscriber if an application for Coverage for that child has not been made within 31 days following the child's birth.

Continuation of Coverage

A. Continuation of Coverage - Federal Law

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

1. Eligibility

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

a. Subscribers

Loss of Coverage because of:

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

b. Covered Dependents

Loss of Coverage because of:

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

2. Enrolling for COBRA Continuation Coverage

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

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

You have sixty (60) days from the qualifying event or the date Your notice of Your right to COBRA Continuation Coverage is mailed, whichever is later, to enroll for such Coverage. The Group will send You the forms that should be used to enroll for COBRA Continuation Coverage. If You do not send the Enrollment Form to the Group within that sixty (60) day period, You will lose Your right to COBRA Continuation Coverage under this section. If You are qualified for COBRA Continuation Coverage and receive services that would be Covered Services, before enrolling and paying the Premium for

such Coverage, You will be required to pay for those services. The Plan will reimburse You for Covered Services, less required Member Payments, after You enroll and pay the Premium for Coverage, and submit a claim for those Covered Services as set forth in this EOC.

3. Premium Payment

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

4. Coverage Provided

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

5. Duration of Eligibility for COBRA Continuation Coverage

COBRA Continuation Coverage is available for a maximum of:

a. Eighteen (18) months if the loss of Coverage is caused by termination of employment or reduction in hours of employment; or
b. Twenty-nine (29) months of Coverage. If, as a qualified beneficiary who has elected eighteen (18) months of COBRA Continuation Coverage, You are determined to be disabled within the first sixty (60) days of COBRA Continuation Coverage, You can extend Your COBRA Continuation Coverage for an additional eleven (11) months, up to twenty-nine (29) months. Also, the twenty-nine (29) months of COBRA Continuation Coverage is available to all non-disabled qualified beneficiaries in connection with the same qualifying event. "Disabled" means Disabled as determined under Title II or XVI of the Social Security Act. In addition, the Employer or the administrator must be notified:
    i. Of the disability determination within sixty (60) days after the determination of disability and before the close of the initial eighteen (18) month Coverage period; and

ii. Within thirty (30) days of the date of a final determination that the qualified beneficiary is no longer Disabled; or

c. Thirty-six (36) months of Coverage if the loss of Coverage is caused by:

i. The death of the Subscriber;
ii. Loss of dependent child status under the Plan;
iii. The Subscriber becomes entitled to Medicare; or
iv. Divorce or legal separation from the Subscriber; or

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

6. Termination of COBRA Continuation Coverage

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

a. The Premium for such Coverage is not paid when due; or
b. You become covered as either a Subscriber or dependent by another group health care plan; or
c. The Group Agreement is terminated; or
d. You become entitled to Medicare coverage; or
e. The date that a Disabled Member, who is otherwise eligible for twenty-nine (29) months of COBRA Continuation Coverage, is determined to no longer be Disabled for purposes of the COBRA law.

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

B. Conversion Options

If Your Coverage under this EOC terminates, You may be eligible for other insurance coverage. You and Your family may be able to buy individual insurance directly from Us or through the Health Insurance Marketplace. Please contact Your broker, call 1-(800) 845-2738 or visit bcbst.com or www.healthcare.gov for more information.

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

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

1. Up to twelve (12) weeks of unpaid leave from employment due to certain family or medical circumstances; or

2. In some instances, up to twenty-six (26) weeks of unpaid leave if related to certain family members' military service-related hardships.

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

D. Continued Coverage During a Military Leave of Absence

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

E. Continued Coverage During Other Leaves of Absence

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

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

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

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

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

Prior Authorization, Care Management, Medical Policy and Patient Safety

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

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

A. Prior Authorization

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

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

1. Inpatient hospital and inpatient hospice stays (except maternity, initial admission only, and Emergency admissions);
2. Skilled nursing facility and rehabilitation facility admissions;
3. Certain outpatient Surgeries and/or procedures;
4. Certain air ambulance services;
5. Certain Specialty Drugs;
6. If Covered by this EOC, certain Prescription drugs;
7. Certain Advanced Radiological Imaging services;
8. Certain durable medical equipment (DME);
9. Certain prosthetics;
10. Certain orthotics;
11. Certain musculoskeletal procedures (including, but not limited to, spinal Surgeries, spinal injections, and hip, knee and shoulder Surgeries);
12. Organ transplants;
13. Certain genetic testing;
14. Certain sleep studies;
15. Certain Behavioral Health Services;
16. Other services not listed at the time of publication may be added to the list of services that require Prior Authorization. Visit bcbst.com/PriorAuthorization or call Our consumer advisors at the Member Service number on the back of Your Member ID card to find out which services require Prior Authorization.

If you receive services that require Prior Authorization, and Prior Authorization is not obtained, your benefits could be reduced, depending on the type of service, Provider location and Provider network status.

Provider Network Status/Type of Service	Within Tennessee	Outside of Tennessee
Network Provider/Inpatient Facility Charges	The Network Provider is responsible for obtaining Prior Authorization. You are not responsible for any Penalty or reduction in benefits, unless You have signed a document agreeing to the service regardless of Coverage.	The BlueCard PPO Participating Provider is responsible for obtaining Prior Authorization. You are not responsible for any Penalty or reduction in benefits, unless You have signed a document agreeing to the service regardless of Coverage.
Network Provider/All Other Services	The Network Provider is responsible for obtaining Prior Authorization. You are not responsible for any Penalty or reduction in benefits, unless You have signed a document agreeing to the service regardless of Coverage.	You are responsible for obtaining Prior Authorization. Please call the Member Service number on the back of Your Member ID card to speak to a consumer advisor. Your benefits may be reduced if Prior Authorization is not obtained.[1]
Out-of-Network Provider/All Services	You are responsible for obtaining Prior Authorization. Please call the Member Service number on the back of Your Member ID card to speak to a consumer advisor. Your benefits may be reduced if Prior Authorization is not obtained.[1]	You are responsible for obtaining Prior Authorization. Please call the Member Service number on the back of Your Member ID card to speak to a consumer advisor. Your benefits may be reduced if Prior Authorization is not obtained.[1]

1 - If the reduction in benefits results in liability to You greater than $2,500 above what You would have paid had Prior Authorization been obtained, then You may contact Our consumer advisors to have the claim reviewed and adjusted to limit the reduction to $2,500. Services that are not determined to be Medically Necessary are not Covered.

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

B. Care Management

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

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

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

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

C. Emerging Health Care Programs – BlueCross is continually evaluating emerging health care programs. These are processes or programs that demonstrate the potential to improve access, quality, efficiency and/or Member satisfaction.

When We approve an emerging health care program, approved services provided through that program are Covered, even though they may normally be excluded under this EOC. We also may adjust Member Payments for approved services through an emerging health care program and take other steps We believe will improve the effectiveness of the emerging health care program.

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

D. Medical Policy

BlueCross BlueShield of Tennessee medical policies address existing, new and emerging medical technologies and services.

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

Medical policies state whether a Technology is Medically Necessary, Investigational, not Medically Necessary or Cosmetic. As Technologies change and improve, and as Members'

needs change, We may reevaluate and change medical policies without formal notice. Visit bcbst.com/mpm to review Our medical policies.

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

E. Patient Safety

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

Health and Wellness

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

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

Decision Support Tools – With these resources, You can get help with handling health issues, formulating questions to ask Your doctor, understanding symptoms and exploring health topics and wellness tips that matter to You most. We also offer a shopping and decision support program, and You can obtain information about the average amount paid to Network Providers and estimates of Your out-of-pocket costs for certain items and services by using our healthcare cost estimator. You can access the healthcare cost estimator by logging in at bcbst.com and clicking on the find care tab, or by logging into the mobile app and choosing the find cost option.

Diabetes Management Program – The Diabetes Management Program supports Members with diabetes to help them better manage their condition through real-time blood glucose monitoring, personalized insights, 24/7 support, access to clinical coaches for diabetes education and support, health notifications and reminders and reports they can share with their providers.

Upon registration, the Member will be provided with a connected blood glucose meter and an unlimited supply of test strips and lancets, with no out-of-pocket costs, to help make diabetes management easier for Members enrolled in the program. Test strips can be ordered directly from the blood glucose meter or the mobile app.

Qualifying Members that have not registered will receive a combination of emails and/or mailers to encourage enrollment.

Digital MSK Clinic (Hinge Health) – This program offers care for different musculoskeletal needs. The program goes beyond digital physical therapy by including app-based exercise therapy and wearable sensors as well as health/behavioral coaches and in-house orthopedic surgeons. The care is led by physical therapists and clinical experts in the following areas: occupational therapy, ergonomists, behavioral health, and pharmacy. This program can positively impact pain, mental health, productivity, and likelihood of surgery. Log in at bcbst.com to determine if you're eligible or call 1-844-269-2583 for more information.

Digital Self-Guided Programs – Our digital learning tools allow You to work on a healthy habit one step at a time. Participate in a variety of journeys that provide guidance and support through structured multi-step courses.

24/7 Nurseline – This program provides You access to nurses twenty-four (24) hours a day, seven (7) days a week. Our nurses can help with symptom assessment, general health information, self-care education and personalized support. Connect with a nurse at 1-(800) 818-8581 or for hearing impaired TTY 1-(888)-308-7231.

Health Trackers – Select habits to track that align with Your wellbeing goals including getting active, eating healthy, sleeping well, managing stress, and being productive.

Blue365® – The Blue365 Member discount program provides savings on a range of health-related products and services, including apparel and footwear, fitness, hearing and vision, home and family, nutrition, personal care, and travel.

Fitness Your Way™ – Fitness Your Way is a discount fitness program that is intended to help You get and stay fit with access to a nationwide network of fitness facilities as well as live and recorded virtual fitness classes. You also have access to discounts for complementary and alternative medicine services.

Healthy Maternity – This program provides You access to prenatal health education and telephonic support and digital case management. You can participate by phone or by using the CareTN mobile app. For more information, log in at bcbst.com/HealthyMaternity or contact Us at 1-(800) 818-8581.

Teladoc virtual care – This program provides You access to a licensed health care practitioner via phone, tablet or computer. Practitioners provide consultations for minor conditions such as allergies, bronchitis, skin infections, sore throat, cold and flu, ear infections and pink eye. Mental Health services are available for anxiety, depression, child behavior issues, mood swings and other conditions. Not all conditions are appropriate for a consultation. Call 1-(800) 835-2362, for hearing impaired TTY 1-(855) 636-1578, or log in at bcbst.com for more information regarding services appropriate for consultations.

This service does not replace Emergency care or Your primary physician. When You have coverage under another health care benefit plan, benefits for this program may apply without reduction. Refer to “Attachment C: Schedule of Benefits” for benefit and cost share information.

Incentive Programs – We may offer voluntary wellness or health improvement programs under which You may be able to earn rewards or incentives. Those rewards or incentives may include cash or cash equivalents, merchandise, gift cards, debit cards, Premium discounts or rebates, contributions toward Your health savings account (if applicable), or modifications to a Copayment, Coinsurance or Deductible amount.

We will let You know if You have the opportunity to participate in a voluntary wellness or health improvement program or have the opportunity to earn incentives for choosing cost-effective providers.

Any reward You receive under such a program may be taxable. Talk to Your tax advisor for guidance.

Also, if You think You might not be able to meet a standard for a reward or incentive under the program because of health reasons, You might qualify for an opportunity to earn the same reward by different means. Call the Member Service number on the back of Your Member ID card and We will work with You (and, if You wish, with Your doctor) to find a program with the same reward or incentive that is right for You in light of Your health status. In some cases, We

may require a note from Your doctor explaining how Your health status affects Your ability to earn a reward or incentive.

If You have any questions about the requirements of a voluntary wellness or health improvement program, call the Member Service number on the back of Your Member ID card.

Inter-Plan Arrangements

Out-of-Area Services

A. Overview

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

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

B. Inter-Plan Arrangements Eligibility – Claim Types

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

C. BlueCard® Program

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

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

i. The billed charges for Covered Services; or

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

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

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

D. Special Cases: Value-Based Programs

1. BlueCard® Program

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

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

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

F. Non-Participating Providers Outside Our Service Area

1. Member Liability Calculation

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

2. Exceptions

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

G. Blue Cross Blue Shield Global® Core

If You are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), You may be able to take advantage of Blue

Cross Blue Shield Global Core when accessing Covered Services. The Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists You with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when You receive care from providers outside the BlueCard service area, You will typically have to pay the providers and submit the claims Yourself to obtain reimbursement for these services.

If You need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, You should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**

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

- **Outpatient Services**

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

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

  When You pay for Covered Services outside the BlueCard service area, You must submit a claim to obtain reimbursement. For institutional and professional claims, You should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of Your claim. The claim form is available from Us, the service center or online at www.bcbsglobalcore.com. If You need assistance with Your claim submission, You should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

Claims and Payment

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

A. Claims

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

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

B. Claims Billing

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

   If You are charged or receive a bill to be reimbursed, You must submit the claim to Us within ninety (90) days from the date a Covered Service was received. If it is not reasonably possible for You to submit the claim to Us within ninety (90) days from the date a Covered Service was received, You must submit the claim as soon as reasonably possible thereafter. Regardless, We will not pay the claim if You submit it to Us later than one (1) year and ninety (90) days from the date the Covered Service was received,

unless You can demonstrate that You could not do so because You were legally incapacitated.

3. The medical, dental and vision claim forms can be found at bcbst.com/medicalclaimform, bcbst.com/dentalclaimform or bcbst.com/visionclaimform. You may also request a claim form by contacting Our consumer advisors. We will send You a claim form within fifteen (15) days. You must submit proof of payment acceptable to Us with the claim form to the applicable address below. We may also request additional information or documentation if it is reasonably necessary to make a Coverage decision concerning a claim.

   Mail medical and dental claim forms to:

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

   Mail pediatric vision claims to BlueCross's vision claims administrator:

   American Administrators, Inc.
   ATTN: OON CLAIMS
   P.O. Box 8504
   Mason, OH 45040

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

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

C. Payment

1. If You received Covered Services from a Network Provider, We will pay the Network Provider directly. You authorize assignment of benefits to that Network Provider. If You have paid that Provider for the same claim, You must request a refund from that Provider.

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

3. If the Group Agreement is terminated, all claims for Covered Services rendered prior to the termination date must be submitted to Us within one (1) year and ninety (90) days from the date the Covered Services were received.
4. We will pay benefits within thirty (30) days after We receive a claim form that is complete. Claims are processed in accordance with Our internal administration procedures and based on the information in Our possession at the time We receive the claim form. We are not responsible for overpayment or underpayment of claims if Our information is not complete or is inaccurate. We will make reasonable efforts to obtain and verify relevant facts when claim forms are submitted.
5. You will receive a Claim Summary that describes how a claim was treated. The Claim Summary, also referred to as the Explanation of Benefits (EOB), shows how a claim was paid, denied, how much was paid to the Provider, and any amounts You owe to that Provider. We will make the Claim Summary available to You at bcbst.com/claims, or You can obtain it at no cost by calling Our consumer advisors at the Member Service number on the back of Your Member ID card.
6. You are responsible for paying any applicable Copayments, Coinsurance or Deductible amounts to the Provider. If We pay such amounts to a Provider on Your behalf, We may collect those amounts directly from You.

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

Coordination of Benefits

This EOC includes the following Coordination of Benefits (COB) provision that applies when a Member has Coverage under more than one group contract or health care benefit plan.

Rules of this section determine whether the benefits available under this EOC are determined before or after those of another plan. In no event, however, will benefits under this EOC or the Group Agreement be increased because of this provision.

If the other plan does not contain provisions establishing the order of benefit determination rules, the benefits under the other plan will be determined first. If this COB provision applies, the order of benefits determination rules control. Those rules determine whether the benefits of this Plan are determined before or after those of another plan.

A. Definitions

The following terms apply to this provision:

1. Types of coverages to which this provision applies and with which coordination of benefits is allowed includes any form of medical or dental coverage including:
   a. Group, blanket or franchise insurance;
   b. A group BlueCross plan or BlueShield plan;
   c. Group or group-type coverage through Health Maintenance Organizations (HMOs) or other prepayment, group practice and individual practice plans;
   d. Coverage under labor management trust plans or Employee benefit organization plans;
   e. Coverage under government programs to which an Employer contributes or makes payroll deductions;
   f. Coverage under a governmental plan or coverage required or provided by law;
   g. Medical benefits coverage in group, group-type, and individual automobile “no-fault” and traditional automobile “fault” type contracts;
   h. Coverage under Medicare and other governmental benefits; and
   i. Any other arrangement of health coverage for individuals in a group.
2. Specifically excluded from the application of Coordination of Benefit rules is an individual (or the individual’s family) with:
   a. Insurance contracts;
   b. Subscriber contracts;
   c. Coverage through HMOs;
   d. Coverage under other prepayment, group practice and individual practice plans;
   e. Public medical assistance programs (such as TennCare[sm]);

f. Group or group-type hospital indemnity benefits of $100 or less per day; and

g. School accident-type coverages.

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

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

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

4. Primary Plan/Secondary Plan

   a. The order of benefit determination rules state whether This Plan is a primary plan or secondary plan as to the Other Plan covering You.

   b. When This Plan is a primary plan, its benefits are determined before those of the Other Plan. We do not consider the Other Plan's benefits.

   c. When This Plan is a secondary plan, its benefits are determined after those of the Other Plan and may be reduced because of the Other Plan's benefits.

   d. When there are more than two plans covering the person, This Plan may be a primary plan as to one or more Other Plans and may be a secondary plan as to a different Other Plan.

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

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

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

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

B. Order of Benefit Determination Rules

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

1. Non-Dependent/Dependent

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

a. If the person is also a Medicare beneficiary and;

b. If the rule established by the Social Security Act of 1965 (as amended) makes Medicare secondary to the plan covering the person as a dependent of an active Employee, then the order of benefit determination shall be:

   i. Benefits of the plan of an active Employee covering the person as a dependent;

   ii. Medicare;

   iii. Benefits of the plan covering the person as an Employee, Member, or Subscriber.

2. Dependent Child/Parents Not Separated or Divorced

   Except as stated in paragraph c. below, when This Plan and the Other Plan cover the same child as a dependent of different persons, called "parents:"

   a. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

   b. If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time.

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

3. Dependent Child/Separated or Divorced Parents

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

   a. First, the plan of the parent with custody of the child;

   b. Then, the plan of the spouse of the parent with the custody of the child; and

   c. Finally, the plan of the parent not having custody of the child.

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

   e. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit

determination rules outlined above, “Dependent Child/Parents Not Separated or Divorced.”

4. Active/Inactive Employee

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

5. Longer/Shorter Length of Coverage

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

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

   b. The start of the new plan does not include:

      i. A change in the amount or scope of a plan’s benefits;

      ii. A change in the entity that pays, provides, or administers the plan’s benefits; or

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

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

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

   Some plans declare their coverage “in excess” to all other plans, “always secondary” or otherwise not governed by COB rules. These plans are called “Non-Complying Plans.”

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

   a. If This Plan is the primary plan, it will provide its benefits on a primary basis.

   b. If This Plan is the secondary plan, it will provide benefits first, but the amount of benefits and liability of This Plan will be limited to the benefits of a secondary plan.

   c. If the Non-Complying Plan does not provide information needed to determine This Plan’s benefits within a reasonable time after it is requested, This Plan will assume that the benefits of the Non-Complying Plan are the same as the benefits of This Plan and provide benefits accordingly. However, This Plan must adjust any payments

it makes based on such assumption whenever information becomes available as to the actual benefits of the Non-Complying Plan.

d. If:

   i. The Non-Complying Plan reduces its benefits so that the Employee, Subscriber or Member receives less in benefits than he or she would have received had the complying plan paid or provided its benefits as the secondary plan, and the Non-Complying Plan paid or provided its benefits as the primary plan; and

   ii. Governing Tennessee law allows the right of subrogation set forth below;

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

C. Effect on the Benefits of This Plan

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

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

   a. The benefits that would be payable for the Allowable Expenses under This Plan, in the absence of this COB provision; and

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

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

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

3. We may not, however, consider the benefits of the Other Plan(s) in determining benefits under This Plan when the Other Plan has a rule coordinating its benefits with those of This Plan and the rule of the Other Plan states that benefits of the Other Plan will be determined after those of This Plan.

D. Right to Receive and Release Needed Information

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

E. Facility of Payment

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

F. Right of Recovery

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

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

The amount of the Payment Made includes the reasonable cash value of any benefits provided in the form of services.

G. Are You Also Covered by Medicare?

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

Grievance Procedure

A. Introduction

Our grievance procedure is intended to provide a method through which a Member can request a review of an Adverse Benefit Determination.

Under this grievance procedure, a claim will not be an Adverse Benefit Determination if a Provider is required to hold You harmless for the cost of services rendered.

Please contact Our consumer advisors at the Member Service number on the back of Your Member ID card (1) to file a claim; (2) if You have any questions about this EOC or other documents related to Your Coverage (e.g. a Claim Summary, sometimes referred to as the Explanation of Benefits (EOB) or monthly claims statement); or (3) to initiate a grievance.

1. This grievance procedure must be exhausted as required by ERISA. However, nothing in this EOC shall prevent You from filing a complaint with the Tennessee Department of Commerce and Insurance, but such complaint is outside of, separate from, and in addition to this grievance procedure.
2. This grievance procedure can only resolve grievances that are subject to Our control.
3. You cannot use this grievance 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 Us, however, to complain about any matter related to the quality or availability of services or any other aspect of Your relationship with Providers.
4. You may request a form to authorize another person to act on Your behalf concerning a grievance.
5. Any grievance filed pursuant to this section will be resolved in accordance with applicable Tennessee or federal laws and regulations and this EOC.

B. Description of the Review Procedures

1. Inquiry

   An inquiry is an informal process that may answer questions or resolve a potential grievance. You should contact Our consumer advisors if You have any questions about how to file a claim or to attempt to resolve any grievance. Making an inquiry does not stop the time period for filing a claim or beginning a grievance. You do not have to make an inquiry before filing a grievance.

2. First Level Grievance

   You must submit a written request asking the Plan to reconsider an Adverse Benefit Determination. You must begin the grievance process within one-hundred and eighty (180) days from the date We issue notice of an Adverse Benefit Determination. If You do not initiate a grievance within one-hundred and eighty (180) days of when We issue an Adverse Benefit Determination, We may raise Your failure to initiate a grievance timely

as a defense if You file a lawsuit against Us later. The grievance process that was in effect on the date(s) of service for which You received an Adverse Benefit Determination will apply.

Contact Our consumer advisors at the Member Service number on the back of Your Member ID card for assistance in preparing and submitting Your grievance. They can provide You with the appropriate form to use in submitting a grievance. This is the first level grievance procedure and is mandatory.

a. Grievance Hearing

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

b. Written Decision

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

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

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

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

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

i. A statement of the committee's understanding of Your grievance;

ii. The basis of the committee's decision; and

iii. Reference to the documentation or information upon which the committee based its decision. The Plan will send You a copy of such documentation or information, without charge, upon written request.

3. Second Level Grievance

You may file a written request for reconsideration within ninety (90) days after We issue the first level grievance committee's decision. This is called a second level grievance. This step is a voluntary step in the grievance procedure. 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 this Evidence of Coverage 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.

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

a. Grievance Hearing

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

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

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

   ii. 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 may be able to make a closing statement to the committee.

   iii. If You wish to appoint a personal representative, You must notify Us at least five (5) days in advance, provide the name, address and telephone number of Your personal representative, and provide a personal authorization form.

b. Written Decision

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

   i. A statement of the second level committee's understanding of Your grievance;

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

   iii. 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.

C. Independent Review of Medical Necessity Determinations or Rescissions

If Your grievance involves a Medical Necessity, Investigational or Rescission determination, or grievances with the respect to Emergency Care Services rendered at an out-of-network hospital, items and services rendered by an Out-of-Network Provider at an in-network hospital (unless You agreed with the Provider prior to the services to accept out-of-network terms under regulatory requirements) and Authorized air ambulance services, then either (1) after completion of the mandatory first level grievance; or (2) after completion of the mandatory first level grievance followed by completion of the voluntary second level grievance, You may request that the grievance be submitted to a neutral third party, selected by the Plan, to independently review and resolve such grievances. If You request an independent review following the mandatory first level grievance, You waive Your right to a second level grievance and Your right to present testimony during the grievance procedure. Your request for independent review must be submitted in writing within one-hundred and eighty (180) days after the date You receive notice of the committee's decision. Receipt shall be deemed to have occurred no more than two (2) days after the date of issuance of the committee's decision. Any person involved in making a decision concerning Your grievance 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 this EOC. If You request independent review of an ERISA Action, We agree to toll any time defenses or restrictions affecting Your right to bring a civil action against the Plan until the independent reviewer makes its decision.

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

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

The reviewer must make a decision within forty (40) calendar days after receipt of the independent review request. The reviewer must then notify Us within two (2) calendar days of its decision. We will then notify You within three (3) calendar days after receiving the reviewer's decision. In the case of a life-threatening condition, the decision must be issued within seventy-two (72) hours after receiving the review request. Except in cases involving a life-threatening condition, the reviewer may request an extension of up to five (5) business days to issue a determination to consider additional information submitted by You or Us.

The reviewer's decision must state the reasons for the determination based upon (1) the terms of this EOC and the Group Agreement; (2) Your medical condition; and (3)

information submitted to the reviewer. The reviewer's decision may not expand the terms of Coverage of the Group Agreement.

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

Statement of ERISA Rights

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

1. Examine, without charge, at the office of the Plan administrator (Plan sponsor, usually Your Employer) and at other specified locations, such as worksites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;
2. Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Services) and updated Plan description. The Plan administrator may make a reasonable charge for these copies;
3. Receive a summary of the Plan's annual financial report. The Plan administrator (Plan sponsor, usually Your Employer) is required by law to furnish each participant with a copy of this summary annual report;
4. Continue Your health care Coverage if there is a loss of Coverage under the Plan as a result of a qualifying event. You may have to pay for such Coverage. Review the "Continuation of Coverage" section of this EOC for the rules governing Your COBRA Continuation Coverage rights.

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

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of Plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, You may file suit in a federal court. In such a case, the court may require the Plan administrator (Plan sponsor, i.e., Your Employer) to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan administrator. If Your claim for benefits is denied or ignored, in whole or in part, You may file suit in a state or federal court. Also, if You disagree with the Plan's decision (or lack thereof) concerning the qualified status of a domestic relations order or a Qualified Medical Child Support Order, You may file suit in a federal court. If

Plan fiduciaries misuse the Plan's money or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or may file suit in a federal court.

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

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

Notice of Privacy Practices

Important Privacy Information

Effective Date 01/01/2026

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

Legal Obligations

The law requires BlueCross BlueShield of Tennessee, Inc. and certain subsidiaries and affiliates ("we," "us," "our") to give this notice of privacy practices to all our members. This notice lets you know about our legal duties and your rights when it comes to your information and privacy.

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

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

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

Privacy Office
BlueCross BlueShield of Tennessee
1 Cameron Hill Circle Chattanooga, TN 37402
Phone: **(888) 455-3824**
Fax: **(423) 535-1976**
E-mail: privacy_office@bcbst.com

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

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

Organizations This Notice Covers

This notice applies to BlueCross BlueShield of Tennessee, Inc. We may share your information with any of the following subsidiaries and affiliates as set forth below: Shared Health, Inc.,

Group Insurance Services, Inc., Volunteer State Health Plan, Inc., Golden Security Insurance Co., SecurityCare of Tennessee, Inc., and Shared Health Mississippi, Inc.

These entities support us in providing health insurance and related products and services. If we buy or create new affiliates or subsidiaries, they may also be required to follow the privacy practices outlined in this notice.

For additional information, including TTY/TDD users, please call the Privacy Office at **1-888-455-3824**. Para obtener ayuda en español, llame al 1-888-455-3824.

How We May Use and Share Your Information

We typically use your information for treatment, payment or health care operations. Sometimes we are allowed, and sometimes we are required, to use or share your information in other ways. This is usually to contribute to the public good, such as public health and research. Information that has been shared may be shared again and no longer protected by federal or state law.

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

Information about members and former members may be used and shared for treatment, payment and health care operations.

We restrict access to information about you to those employees or contractors who need to know that information to run our business. We maintain physical, electronic and procedural safeguards that comply with federal regulations to guard your information.

Sources of Information We Collect and Share

We collect information about you from the following sources:

1. **Information we receive from you:** We collect information directly from you. For example, we collect information like your name, address, and social security number when you apply for insurance or complete other forms, and we collect information like your name and contact information when you contact us for customer service requests.
2. **Information about your transactions with us and our affiliates:** We collect information about your relationship with us and with our affiliates. For example, we collect information about the claims we process like when you received health care, what services are covered, and how much we've paid. We sometimes use affiliates and related entities to provide administrative services to process those claims, and they provide us with the same type of information about you.
3. **Information about your transactions with non-affiliated third parties:** We collect health plan information about your relationship with non-affiliated third parties such as healthcare providers. For example, when your healthcare provider submits claims to us, it includes

health plan information about your care like diagnostic information, procedures you've had, and the date of service.

As permitted by law and this notice, we may use and share all the information we have about you as described above.

Ways We May Use and Share Your Information

We may use and share any of the information we have about you, including to nonaffiliated third parties, in accordance with federal and state laws. The following are examples of how we may use or share your information and the types of third parties with whom we may share your information.

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

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

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

To work with plan sponsors: We may share your information with your employer-sponsored group health plan (if applicable) for plan administration. For example, we may use or share it to help verify your identity or to give you more information about your health insurance options. Please see your plan documents for all the ways a plan sponsor may use this information.

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

Research: We may use or share your information in connection with lawful research purposes. For example, we may share your information as part of a limited data set given to a researcher for clinical research.

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

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

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

- Preventing or reducing a serious threat to anyone's health or safety

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

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

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

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

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

For example, we would need your written authorization for:

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

We will let you know if any of these circumstances arise. We cannot use or share information except as described in this notice without your written authorization.

Certain types of your information are treated differently.

Substance Use Disorder Information: We may receive substance use disorder treatment information about you from certain providers that are subject to federal regulations governing the confidentiality of such information. We may not use or share such information in any civil, criminal, administrative, or legislative proceedings against you unless (1) you consent in writing, or (2) a court order is issued after notice and an opportunity to be heard is provided and is accompanied by a subpoena or similar legal mandate compelling disclosure.

Your Individual Rights

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

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

To see who we've shared your information with: You have the right to receive a list of most disclosures we (or a business associate on our behalf) made of your information within the last six (6) years, other than those made for the purpose of treatment, payment or health care operations, and certain other disclosures. This list will include the date of the disclosure, what information was shared, the name of the person or entity it was shared to, the reason for the disclosure and some other information.

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

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

To get notified of a breach: We will notify you after an unauthorized acquisition, access, use, or disclosure of your health information that compromises the security or privacy of the information.

To ask for confidential communications: You have the right to ask us in writing to send your information to you at a different address or by a different method if you believe that sending information to you in the normal manner will put you in danger. We have to grant your request if it's reasonable. We will also need information from you, including how and where to communicate with you. Your request must not interfere with payment of your premiums. If there's an immediate threat, you may make your request by calling the Member Service number on the back of your Member ID card or the Privacy Office. Please follow up your call with a written request as soon as possible.

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

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

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

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

General Legal Provisions

The Plan is an Independent Licensee of the Blue Cross Blue Shield Association

You acknowledge this EOC is a contract solely between You and Us. We are an independent corporation operating under a license from the Blue Cross Blue Shield Association, an association of independent BlueCross and BlueShield Plans (the "Association"). The Association permits Us to use the Association's service marks in Our service area. We are not contracting as an agent of the Association. You further acknowledge and agree that:

1. You have not entered into this EOC based upon representation by any person other than Us; and
2. No person, entity or organization other than Us shall be held accountable or liable to You for any of the obligations to You created under this EOC.

This paragraph shall not create any additional obligations on Our part other than those created under this EOC.

Continuity of Care

When a Network Provider no longer has an agreement with Us and becomes an Out-of-Network Provider, benefits will be available for Covered Services received from such Provider after such Provider terminates its agreement with Us or We terminate such agreement without cause. Benefits will be available as if such Provider were still a Network Provider:

1. For up to one-hundred and twenty (120) days following notice that the agreement between the Provider and Us has been terminated, provided the Member was under an active course of treatment for a particular illness or injury on the date such agreement was terminated and Covered Services are for the same illness or injury; or
2. Until completion of postpartum care, if the Member was in the second or third trimester of pregnancy on the date such agreement was terminated; or
3. Until discharge, if the Member was under treatment at an inpatient facility on the date such agreement was terminated.

The now Out-of-Network Provider must agree to continue to provide Covered Services on the same terms and conditions as applied under its former agreement with Us.

Our Payment Methods for Network Providers

Our agreements with Network Providers include different payment arrangements. We use various alternative Provider payment methodologies including, but not limited to, Diagnosis Related Group (DRG) payments, discounted fee-for-service payments, patient-centered medical

home programs, bundled payments for episodes of care, pay-for-performance initiatives, and other quality improvement and/or cost containment programs.

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 forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section. However, as permitted by federal law, We 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 forty-eight (48) hour (or ninety-six (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 an 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 forty-eight (48) hours (or ninety-six (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 Us.

Women's Health and Cancer Rights Act of 1998

Patients who undergo (1) a mastectomy; and (2) elect breast reconstruction in connection with the mastectomy in a manner determined in consultation with the attending physician and patient, are entitled to Coverage for:

1. All stages of reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

The Coverage will be subject to Coinsurance, Copays and Deductibles consistent with those established for other benefits. Please refer to "Attachment C: Schedule of Benefits" or call Our consumer advisors for more details.

Uniformed Services Employment and Reemployment Rights Act of 1994

You may continue Your Coverage and Coverage for eligible dependents during military leave of absence in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994. When the Subscriber returns to work from a military leave of absence, the Subscriber

will be given credit for the time the Subscriber was Covered under the Plan prior to the leave. Check with the Employer to see if this provision applies.

Governing Laws

To the extent not governed by federal law, the laws of the State of Tennessee govern Your benefits.

Subrogation and Right of Recovery

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

We may enforce Our rights of subrogation and recovery against, without limitation, any tortfeasors, any responsible parties or against any available insurance coverages. Such actions may be based in tort, contract, or other cause of action to the fullest extent permitted by law. Accordingly, the Plan has the right to recover equal to the Plan's payments from sources that include, but are not limited to:

1. The insurance of the injured party;
2. The person or company (or combination thereof) that caused the illness or injury, or their insurance company; or
3. Any other source, including, but not limited to, any liability coverage, uninsured or underinsured motorist coverage, umbrella coverage, no-fault insurance coverage, business and homeowner's insurance coverage, medical payment coverage, worker's compensation insurance or fund, school accident coverage, or any other medical reimbursement policies.

This right of recovery under these provisions will apply whether recovery was obtained by suit, settlement, mediation, arbitration, or otherwise. Moreover, the Plan's rights of subrogation and/or recovery apply regardless of whether such payments are designated as payment for (but not limited to) pain and suffering, medical benefits, and/or other specified damages. It also applies regardless of whether the Member is a minor. Likewise, if the Member's relatives, heirs, wrongful death beneficiaries, and /or other assignees make a recovery because of injuries sustained by the Member, that recovery shall be subject to these provisions. The Group has agreed that You shall be required to notify the Plan if You are involved in an incident that gives rise to such rights for subrogation and recovery to enable the Plan to protect its rights under this section. You are also required to cooperate with the Plan and to execute any documents that the Plan deems necessary to protect its rights under this section. Additionally, the Plan has the right to sue on Your behalf, against any person or entity considered responsible for any condition resulting in medical expenses, to recover benefits paid or to be paid by the Plan. However, nothing within these provisions require the Plan to intervene in any lawsuit or proceeding in order for the Plan to enforce its rights under this section from any recovery

obtained. You shall not do anything to hinder, delay, impede or jeopardize the Plan's subrogation rights and/or right of reimbursement.

The Plan shall have a lien against any payment, judgment, or settlement of any kind that You receive from or on behalf of any party or insurance carrier. The Plan may notify those parties of its lien without notice to or consent from You. Additionally, subject to applicable Tennessee state law or federal ERISA law (whichever controls), the Plan's subrogation and/or right of recovery is in first-priority and is not subject to any made-whole rule or common fund doctrine.

If You settle any claim or action against any party without Our consent, You shall be deemed to have been made whole by the settlement and the Plan shall be entitled to immediately collect the present value of its subrogation and recovery rights from the settlement fund. Any such proceeds of settlement or judgment shall be held in trust by You for the benefit of the Plan.

You agree that the proceeds subject to the Plan's lien are Plan assets and You will hold such assets as a trustee for the Plan's benefit and shall remit to the Plan, or its representative, such assets upon request. If represented by counsel, You agree to direct such counsel to hold the proceeds subject to the Plan's lien in the counsel's trust account and to remit such funds to the Plan, or its representative, upon request.

Nondiscrimination Notice

BlueCross complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex[1]. BlueCross does not exclude people or treat them less favorably because of race, color, national origin, age, disability or sex.

BlueCross:

1. Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with Us, such as:
    a. Qualified sign language interpreters; and
    b. Written information in other formats, such as large print, audio and accessible electronic formats.
2. Provides free language assistance services to people whose primary language is not English, such as:
    a. Qualified interpreters; and
    b. Information written in other languages.

If You need these reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Our consumer advisors at the Member Service number on the back of Your Member ID card or call 1-(800) 565-9140, or for hearing impaired, TTY 1-(800) 848-0298 or 711.

If You believe that BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, You can file a grievance ("Nondiscrimination Grievance"). For help with preparing and submitting Your

Nondiscrimination Grievance, contact Our consumer advisors at the Member Service number on the back of Your Member ID card or call 1-(800) 565-9140, or for hearing impaired, TTY 1-(800) 848-0298 or 711. We can provide You with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address Your Nondiscrimination Grievance to:

Nondiscrimination Grievance

c/o Manager, Operations, Member Benefits Administration

1 Cameron Hill Circle, Suite 0019

Chattanooga, TN 37402-0019

Fax: 1-(423) 591-9208

Email: Nondiscrimination_OfficeGM@bcbst.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue SW, Room 509F, HHH Building

Washington, DC 20201

Phone: 1-(800) 368-1019

TTY: 1-(800) 537-7697

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

You can contact BlueCross's Nondiscrimination Coordinator at 423-535-1010 (TTY: 1-800-848-0298 or 711); Nondiscrimination_CoordinatorGM@bcbst.com (email); or Corporate Compliance, 1 Cameron Hill Circle, 1.4, Chattanooga, TN 37402.

This notice is available at BlueCross's website: bcbst.com.

[1] Consistent with the scope of sex discrimination described at 45 CFR 92.101(a)(2)

Definitions

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

1. **Accountable Care Organization (ACO)** – A group of healthcare providers who agree to deliver coordinated care and meet performance benchmarks for quality and affordability in order to manage the total cost of care for their member populations.
2. **Actively at Work** – An eligible Employee who is performing all of the Employee's regular duties for the Group on a regularly scheduled work day at the location where such duties are normally performed. An Employee will be considered to be Actively at Work on a non-scheduled work day (which would include a scheduled vacation day) only if he or she was Actively at Work on the last regularly scheduled work day.
3. **Acute** – An illness or injury that is both severe and of short duration.
4. **Advanced Radiological Imaging** – Services such as MRIs, CT scans, PET scans, nuclear medicine and similar technologies.
5. **Adverse Benefit Determination** – Any denial, reduction, termination or failure to provide or make payment for what You believe should be a Covered Service. Adverse Benefit Determinations include:
    a. A determination by a health carrier or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health carrier's health benefit plan does not meet the health carrier's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit;
    b. The denial, Rescission, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier of a Member's eligibility to participate in the health carrier's health benefit plan; or
    c. Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment for, in whole or in part, a benefit.
6. **Annual Benefit Period(s)** – The twelve (12) month period under which Your benefits are administered, as noted in "Attachment C: Schedule of Benefits."
7. **Authorize(d)** – A determination made by the Plan at the end of the Prior Authorization process.
8. **Behavioral Health Services** – Services or supplies to treat a mental or emotional condition or substance use disorder.
9. **Billed Charge(s)** – The amount that a Provider charges for services rendered. Billed Charges may be different from the amount that We determine to be the Maximum Allowable Charge for services.

10. **Blue Distinction® Centers for Transplants (BDCT) Network** – A network of facilities and hospitals contracted with BlueCross (or with an entity on behalf of BlueCross) to provide Transplant Services for some or all organ and bone marrow/stem cell transplant procedures Covered under this EOC. Facilities obtain designation as a BDCT by transplant type; therefore, a hospital or facility may be classified as a BDCT for one type of organ or bone marrow/stem cell transplant procedure but not for another type of transplant. This designation is important as it impacts the level of benefits You will receive.
11. **BlueCard PPO Participating Provider(s)** – A physician, hospital, licensed skilled nursing facility, home health care Provider or other Provider who contracts with other Blue Cross and/or Blue Shield licensees and/or whom We have authorized to provide Covered Services to Members.
12. **BlueCross, BlueCross BlueShield of Tennessee, Our, Plan, Us or We** – BlueCross BlueShield of Tennessee, Inc.
13. **Care Coordination** – Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Member's healthcare needs across the continuum of care.
14. **Care Coordination Fee** – A fixed amount paid by a Blue Cross and/or Blue Shield Licensee to providers periodically for Care Coordination under a Value-Based Program.
15. **Care Coordinator** – An individual within a provider organization who facilitates Care Coordination for patients.
16. **Care Management** – Programs that promote cost-effective coordination of care for Members with low-risk health conditions, behavioral health conditions, substance use disorders and/or certain complicated medical or behavioral health needs.
17. **CHIP** – The State Children's Health Insurance Program established under Title XXI of the Social Security Act (42 U.S.C. 1396 et. seq.).
18. **Clinical Trial(s)** – Studies performed with human subjects to test new drugs or combinations of drugs, new approaches to Surgery or radiotherapy or procedures to improve the diagnosis of disease and the quality of life of the patient. Such studies are not Authorized by Us.
19. **Coated Lenses or Coating** – A substance added to a finished lens on one or both surfaces.
20. **Coinsurance** – Sharing of the cost of Covered Services by the Plan and You, after Your Deductible has been satisfied (where applicable). The Plan's Coinsurance amounts for network and out-of-network Covered Services are specified in "Attachment C: Schedule of Benefits." Your Coinsurance is calculated as one-hundred percent (100%) minus the Plan's Coinsurance. Coinsurance applies to the Maximum Allowable Charge for Covered Services.
21. **Complications of Pregnancy** – Conditions requiring Hospital Confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or caused by pregnancy, such as Acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical

conditions of comparable severity, non-elective cesarean section, ectopic pregnancy that is terminated, fetus is not viable and spontaneous termination of pregnancy, that occurs during a period of gestation in which a viable birth is not possible.

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

22. **Compound Drug(s)** – An outpatient Prescription Drug that is not commercially prepared by a licensed pharmaceutical manufacturer in a dosage form approved by the Food and Drug Administration (FDA) and contains at least one (1) ingredient that cannot be dispensed without a Prescription.
23. **Comprehensive Eye Examination** – A general evaluation of the complete visual system. The examination includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields, basic sensorimotor examination and Refraction. It always includes initiation of diagnostic and treatment programs. It may include biomicroscopy, examination with cycloplegia or mydriasis and tonometry, as determined by the Provider. These services may be performed at different sessions, but comprise only one Comprehensive Eye Examination.
24. **Concurrent Review** – The process of evaluating care during the period when Covered Services are being rendered.
25. **Convenience or Convenience Item(s)** – Any service, item, device, software or equipment that is related primarily to the ease or preference of the member, family, caregiver or provider rather than to Medical Necessity of care.
26. **Copay(s) or Copayment(s)** – The dollar amount specified in "Attachment C: Schedule of Benefits" that You are required to pay directly to a Provider or Network Pharmacy for certain Covered Services. You must pay such Copayments at the time You receive those services.
27. **Copay Assistance** – Direct or indirect financial assistance from a third party (such as a pharmaceutical manufacturer or foundation), including coupons or copay assistance.
28. **Cosmetic or Cosmetic Services** – Any surgical or non-surgical treatment, drugs or devices intended to alter or reshape the body for the purpose of improving appearance or self-esteem.
29. **Covered Dependent(s)** – A Subscriber's family member who (1) meets the eligibility requirements of this EOC; (2) has been enrolled for Coverage; and (3) for whom the Plan has received the applicable Premium for Coverage.
30. **Covered Family Member(s)** – A Subscriber and his or her Covered Dependents**.**
31. **Covered Service(s), Coverage or Covered** – Those Medically Necessary and Medically Appropriate services and supplies that are set forth in Attachments A-C of this EOC. Covered Services are subject to all the terms, conditions, exclusions and limitations of the Group

Agreement and this EOC. Covered Services shall not include items or services that are illegal or unlawful when furnished by the Provider.

32. **Custodial Care** – Non-medical care that can reasonably and safely be provided by non-licensed caregivers. This includes, but is not limited to, caregiver training services, eating, bathing, dressing or other activities of daily living.

33. **Deductible(s)** – The dollar amount, specified in "Attachment C: Schedule of Benefits" that You must incur and pay for Covered Services during an Annual Benefit Period before the Plan provides benefits for services. If a claim includes dates of service that span two Annual Benefit Periods, benefits may be subject to a Deductible for each Annual Benefit Period. There are two (2) separate Deductible amounts – one (1) for Network Providers and one (1) for Out-of-Network Providers. The Deductible(s) will apply to the applicable Out-of-Pocket Maximum(s).

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

34. **Dentist** – A doctor of dentistry, duly licensed and qualified under applicable laws to practice dentistry at the time and place Covered Services are performed; Dentist is defined to include any dental professional that is duly licensed and qualified to perform the Covered Services at the time and place Covered Services are performed.

35. **Drug Formulary** – Essential – A list of Prescription Drugs Covered by the Plan and that are subject to Quantity Limits, Prior Authorization or Step Therapy. The Drug Formulary is subject to periodic review and modification at least annually by the Plan's Pharmacy and Therapeutics Committee. The Drug Formulary can be found at bcbst.com/rx or by calling the Member Service number on the back of Your Member ID card.

36. **Effective Date** – The date Your Coverage under this EOC begins.

37. **Emergency(ies)** – A sudden and unexpected medical condition, including a mental health condition or substance use disorder, that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

    a. Serious impairment of bodily functions; or

    b. Serious dysfunction of any bodily organ or part; or

    c. Placing the prudent layperson's health in serious jeopardy.

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

38. **Emergency Care Services** – Those services and supplies that are Medically Necessary and Medically Appropriate in the treatment of an Emergency and delivered in a hospital Emergency department or a licensed independent freestanding emergency department. Emergency Care Services may include items and services after the Member is stabilized and

as part of outpatient observation or an inpatient or outpatient stay related to the Emergency.

39. **Employee(s)** – A person who meets the Group's requirements to apply for Coverage under the Plan.
40. **Enrollment Form** – A form or application that must be completed in full by the eligible Employee before he/she will be considered for Coverage under the Plan. Your Group may have You use an electronic form to enroll, rather than a paper form.
41. **ERISA** – The Employee Retirement Income Security Act of 1974, as amended.
42. **Experimental and/or Investigational Drugs** – Drugs or medicines that are labeled: "Caution – limited by federal law to Investigational use."
43. **Generic Drug(s)** – A Prescription Drug that has the same active ingredients, strength or concentration, dosage form and route of administration as a Preferred Brand Drug or Non-Preferred Brand Drug. The FDA approves each Generic Drug as safe and effective as a specific Preferred Brand Drug or Non-Preferred Brand Drug. Generic Drugs are identified on the Drug Formulary, which can be found at bcbst.com/rx or by calling the Member Service number on the back of Your Member ID card.
44. **Global Payment/Total Cost of Care** - A payment methodology that is defined at the patient level and accounts for either all patient care or for a specific group of services delivered to the patient such as outpatient, physician, ancillary, hospital services and prescription drugs.
45. **Group Agreement or Agreement** – The arrangements between the Plan and the Group, including this EOC, the Employer Group Application, any amendments, and any attachments to the Agreement or this EOC. If there is any conflict between the Group Agreement and this EOC, the Group Agreement shall be controlling.
46. **Group(s) or Employer** – A corporation, partnership, union or other entity that is eligible for Group Coverage under Tennessee and federal laws, and the Plan's underwriting guidelines; and that enters into an Agreement with the Plan to provide Coverage to its Employees and their eligible dependents.
47. **Habilitative Therapy** – Therapies provided to help a person with a disability keep, learn or improve skills and functioning for daily living.
48. **Hearing Aid(s)** – An instrument to amplify sounds for those with hearing loss. There are two (2) types of Hearing Aids: the air conduction type, which is worn in the external acoustic meatus, and the bone conduction type, which is worn in the back of the ear over the mastoid process. Examples of Hearing Aids that would fall within this definition are the Baha® system and the Otomag™ Hearing System. Cochlear implants are a prosthetic and are not considered Hearing Aids.
49. **Home Delivery Network** – BlueCross's network of mail service Pharmacy facilities that are permitted to mail Prescription Drugs.
50. **Hospital Confinement** – When You are treated as a registered bed patient at a hospital or other Provider facility and incur a room and board charge.

51. **Hospital Service(s)** – Covered Services that are Medically Appropriate to be provided by an Acute care hospital.

52. **Incapacitated Child** – An unmarried child of the Subscriber who is Covered under the Plan upon reaching the Plan's Limiting Age, and continues to be, both (1) incapable of self-sustaining employment by reason of intellectual or physical disability and (2) chiefly dependent upon the Subscriber or Subscriber's Covered spouse for economic support and maintenance.

    Proof of such incapacity and dependency must be furnished within 31 days of when the child reaches the Limiting Age.

    Incapacitated dependents of Subscribers of new Groups, or of Subscribers who are newly eligible under this Plan, are eligible for Coverage if they were Covered under the Subscriber's or the Subscriber's Covered spouse's previous health benefit plan. Proof of the incapacity and dependency is required upon enrollment.

    Annual proof of the dependent's continued compliance with the terms of incapacity and dependency may be required.

53. **Investigational** – The definition of Investigational is based on the terms of this Evidence of Coverage, BlueCross's technology evaluation criteria and medical policies. "Investigational" includes Technologies that are experimental. In addition, any Technology that fails to meet **ALL** of the following four criteria may be considered Investigational.

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

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

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

    b. The scientific evidence must permit conclusions concerning the effect of the Technology on a specific diagnosis, as demonstrated by:

        i. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals concerning the use of a Technology for a specific diagnosis. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.

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

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

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

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

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

When Coverage is not addressed by this EOC, applicable medical policy and third-party clinical guidelines adopted by BlueCross or You have unusual, rare or unique circumstances relating to Your condition as determined by the Medical Director, then the Medical Director, in accordance with applicable ERISA standards, shall have discretionary authority to make a determination concerning whether a service or supply is Investigational. If the Medical Director does not Authorize the provision of a service or supply, it will not be a Covered Service. In making such determinations, the Medical Director shall rely upon any or all of the following, at his or her discretion**:**

a. Your medical records; or

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

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

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

e. Regulations or other official publications issued by the FDA and Department of Health and Human Services (HHS); or

f. The opinions of any entities that contract with the Plan to assess and coordinate the treatment of Members requiring non-experimental or Investigational services; or

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

54. **Limiting Age or Dependent Child Limiting Age** – The age at which a child will no longer be considered an eligible dependent.

55. **Mandated Diabetic Supplies** – In accordance with Tenn. Code Ann. § 56-7-2605, the following equipment and supplies for the treatment of diabetes must be included in the Coverage provided pursuant to subsection (b), when prescribed by a physician as Medically Necessary for the care of an individual patient with diabetes:

    a. Blood glucose monitors and blood glucose monitors for the legally blind;

    b. Test strips for blood glucose monitors;

c. Visual reading and urine test strips;

d. Insulin;

e. Injection aids;

f. Syringes;

g. Lancets;

h. Insulin pumps, infusion devices, and appurtenances thereto;

i. Oral hypoglycemic agents;

j. Podiatric appliances for prevention of complications associated with diabetes; and

k. Glucagon Emergency kits.

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

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

58. **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 Prior Authorization program.

59. **Medically Appropriate** – Services which have been determined by BlueCross, in its discretion, to be of value in the care of a specific Member. To be Medically Appropriate a service must:

    a. Be Medically Necessary;

    b. Be consistent with generally accepted standards of medical practice for the Member's medical condition;

    c. Be provided in the most appropriate site and at the most appropriate level of service for the Member's medical condition;

    d. Not be provided solely to improve a Member's condition beyond normal variation in individual development, appearance and aging; and

    e. Not be for the sole Convenience of the Provider, Member or Member's family.

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

a. In accordance with generally accepted standards of medical practice;

b. Clinically appropriate in terms of type, frequency, extent, site and duration; and considered effective for the Member's illness, injury or disease;

c. Not primarily for the Convenience of the Member, physician or other health care Provider; and

d. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that Member's illness, injury or disease.

For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and the views of medical Practitioners practicing in relevant clinical areas and any other relevant factors. The definition of “Medically Necessary or Medical Necessity” applies to both medical services and Behavioral Health Services.

61. **Medicare** – Title XVIII of the Social Security Act, as amended, and coverage under this program.

62. **Medication Assisted Treatment (MAT)** – The use of medications, in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to the treatment of substance use disorders.

63. **Member(s), You or Your** – Any person enrolled as a Subscriber or Covered Dependent under a Group Agreement.

64. **Member Payment(s)** – The dollar amounts for Covered Services that You are responsible for as set forth in “Attachment C: Schedule of Benefits,” including Copayments, Deductibles, Coinsurance and Penalties.

65. **Minimum Essential Coverage** – Coverage under any of the following, as defined in section 5000A(f) of the Internal Revenue Code: (1) government-sponsored programs; (2) an eligible employer-sponsored plan; (3) a health plan offered in the individual market within a state; (4) a grandfathered health plan; or (5) other health benefits coverage, such as a state health benefits risk pool.

66. **Necessary Dental Care** – Any treatment or service prescribed by a Dentist that the Plan determines to be necessary and appropriate.

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

68. **Network Benefit** – The payment level that applies to Covered Services received from a Network Provider. See “Attachment C: Schedule of Benefits.”

69. **Network Dentist(s)** – A Dentist who has signed a preferred dental agreement with the Plan.

70. **Network Pharmacy(ies)** – A Pharmacy that has entered into an agreement with BlueCross or its agent to legally dispense Prescription Drugs to You.

71. **Network Provider(s)** – A Provider who has contracted with the Plan to provide Covered Services to Members at specified rates. Such Providers may also be referred to as BlueCard PPO Participating Providers, participating hospitals, etc. Some Providers may have contracted with the Plan to provide a limited set of Covered Services, such as only Emergency Care Services, and are treated as Network Providers for this limited set of Covered Services.

72. **Non-Contracted Provider(s)** – A Provider in a category or type that collectively does not hold a contract with BlueCross. A Provider's status as a Non-Contracted Provider, Network Provider or Out-of-Network Provider can and does change.

73. **Non-Preferred Brand Drug(s)** – A Prescription Drug identified as a Non-Preferred Brand Drug on the Drug Formulary, which can be found at bcbst.com/rx or by calling the Member Service number on the back of Your Member ID card.

74. **Open Enrollment Period** – Those periods of time agreed to by the Plan and the Group during which eligible Employees and their dependents may enroll as Members.

75. **Ophthalmologist** – A person or a doctor of medicine (M.D.) or osteopathy (D.O.) who specializes in the comprehensive care of the eyes and visual system to prevent, diagnose and treat any eye disease, disorder or injury.

76. **Optician** – One who is licensed to fit, adjust, and dispense eyeglasses and other optical devices on the written Prescription of a licensed Ophthalmologist or Optometrist.

77. **Optometrist** – A doctor of optometry (O.D.) who is trained to detect and correct vision problems primarily by prescribing eyeglasses or contact lenses.

78. **Oral Appliance(s)** – A device placed in the mouth and used to treat mild to moderate obstructive sleep apnea by repositioning or stabilizing the lower jaw, tongue, soft palate or uvula. An Oral Appliance may also be used to treat temporomandibular joint syndrome or dysfunction (TMJ or TMD) by stabilizing the jaw joint. An Oral Appliance is not the same as an occlusal splint, which is used to treat malocclusion or misalignment of teeth.

79. **Out-of-Network Pharmacy** – A Pharmacy that is not a Network Pharmacy**.**

80. **Out-of-Network Provider(s)** – Any Provider who does not have a contract with the Plan to provide Covered Services and who is not a Non-Contracted Provider.

81. **Out-of-Pocket Maximum(s)** – The total dollar amount, as stated in "Attachment C: Schedule of Benefits," that a Member must incur and pay for Covered Services during the Annual Benefit Period, including Copayments, Deductible and Coinsurance. There are two (2) Out-of-Pocket Maximums – one (1) for services rendered by Network Providers and one (1) for services rendered by Out-of-Network Providers.

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

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

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

82. **Oversized Lenses** – Lenses with an eye size of 61mm or greater.
83. **Patient-Centered Medical Home (PCMH)** – A model of care in which each patient has an ongoing relationship with a primary care physician who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified physicians.
84. **Payor** – An insurer, health maintenance organization, no-fault liability insurer, self-insured group, or other entity that provides or pays for a Member's health care benefits.
85. **Penalty(ies)** – An increase in the amount You pay as a result of failure to comply with Plan requirements. Penalties do not apply to the Out-of-Pocket Maximum.
86. **Pharmacy(ies)** – A state or federally licensed establishment that is physically separate and apart from the office of a Practitioner, and where Prescription Drugs are dispensed by a pharmacist licensed to dispense such drugs under the laws of the state in which he or she practices.
87. **Pharmacy and Therapeutics Committee or P&T Committee** – A panel of pharmacists and Practitioners that reviews medications for safety, efficacy and cost-effectiveness. The P&T Committee evaluates medications for addition, deletion and tier assignment in the Drug Formulary, as well as for Prior Authorization and Quantity Limits requirements.
88. **Plus90 Retail Network** – BlueCross's network of retail Pharmacies that are permitted to dispense Prescription Drugs to You, up to a ninety (90) day supply.
89. **Practitioner(s)** – A person licensed by the state to provide medical or Behavioral Health Services. The services provided by a Practitioner must be within his or her specialty or scope of practice.
90. **Preferred Brand Drug(s)** – A Prescription Drug identified as a Preferred Brand Drug on the Drug Formulary, which can be found at bcbst.com/rx or by calling the Member Service number on the back of Your Member ID card.
91. **Premium(s)** – The total payment for Coverage under the Group Agreement, including amounts paid by You and the Group for such Coverage.
92. **Prescription(s)** – A written or verbal order issued by a Practitioner for a drug or medical equipment.

93. **Prescription Contraceptive Drug(s)** – Prescription Drugs that are indicated for the prevention of pregnancy. The current list can be found at bcbst.com/rx or by calling the Member Service number on the back of Your Member ID card.

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

95. **Preventive Health Exam** – An assessment of health status for the purpose of maintaining health and detecting disease in its early state.

96. **Primary Care Practitioner(s)** – The doctor selected to coordinate all of a Member's health care, including routine checkups and treatment for medical problems. A Primary Care Practitioner is typically a doctor in general internal medicine, general practice, family medicine, pediatrics, obstetrics and gynecology, or behavioral health.

97. **Prior Authorization(s)** – A review conducted by the Plan pursuant to the terms in this EOC.

98. **Provider(s)** – A Practitioner or entity engaged in the delivery of health services that is licensed, certified and practicing in accordance with applicable state and federal laws.

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

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

101. **Quantity Limits** – Limits on the amount of Prescription Drugs that can be dispensed for certain Prescription Drugs as determined by the P&T Committee.

102. **Rehabilitative Therapy** – Therapies provided to help a person regain, maintain or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury or disabling condition.

103. **Refraction** – A test performed by a Provider to determine the glasses or contact lens prescription due to a refractive error (for example, nearsightedness, farsightedness, astigmatism or presbyopia).

104. **Rescind or Rescission(s)** – A retroactive termination of Coverage because You or Your Covered Dependent(s) made an intentional misrepresentation of a material fact or committed fraud in connection with Coverage. Actions that are fraudulent or an intentional misrepresentation of a material fact include, but are not limited to, knowingly enrolling or attempting to enroll an ineligible individual in Coverage, permitting the improper use of Your Member ID card or claim fraud.

    A Rescission does not include a situation in which We retroactively terminate Coverage in the ordinary course of business for a period for which You did not pay the Premium. An

example would be if You left Your job on January 31, but the Group did not tell Us until March 15 that You had left. In that situation, We may retroactively terminate Your Coverage effective February 1 if You did not pay any Premium after You left Your job (subject to any right You may have to elect continuation coverage). This is not a Rescission.

105. **RX03 Retail Network** – BlueCross's network of retail Pharmacies that are permitted to dispense Prescription Drugs to You, up to a thirty (30) day supply.

106. **Specialty Drug(s)** – Injectable, infusion and select oral medications that require complex care, including special handling, patient education and continuous monitoring. Specialty Drugs are categorized as Provider-administered or self-administered in this EOC. Specialty Drugs may be available as a Generic Drug, Preferred Brand Drug or Non-Preferred Brand Drug.

107. **Specialty Pharmacy Network** – A Pharmacy that has entered into a Network Pharmacy agreement with the Plan or its agent to legally dispense Specialty Drugs.

108. **Standard Lenses** – Standard glass or plastic (CR39) in clear or Rose Tint #1 or #2. Any lens that will fit any frame with an eye size less than 61 mm.

109. **Step Therapy** – A form of Prior Authorization under which certain Prescription Drugs will not be Covered, unless a first-line therapy Prescription Drug is used first by You. Prescription Drugs subject to Step Therapy guidelines are identified on the Drug Formulary, which can be found at bcbst.com/rx or by calling the Member Service number on the back of Your Member ID card.

110. **Subscriber(s)** – An Employee who meets all applicable eligibility requirements, has enrolled for Coverage and for whom the Plan has received the applicable Premium for Coverage from the Group.

111. **Surgery(ies) or Surgical Procedure(s)** – Medically Necessary and Medically Appropriate Surgeries or procedures. Surgeries involve an excision or incision of the body's skin or mucosal tissues, treatment of broken or dislocated bones, and/or insertion of instruments for exploratory or diagnostic purposes into a natural body opening.

112. **Telehealth** – Remote consultation that meets Medical Necessity criteria.

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

114. **Transplant Service(s)** – Medically Necessary and Medically Appropriate services listed as Covered under the "Organ Transplants" section in "Attachment A: Covered Services and Exclusions."

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

116. **Utilization Policy(ies)** – Refers to any policy, guideline or limitation used by BlueCross in the determination of Coverage.
117. **Value-Based Program (VBP)** – An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.
118. **Vision Examination(s)** – Any eye or visual examination covered under the policy and shown in "Attachment C: Schedule of Benefits."
119. **Vision Materials** – Those materials provided for vision health and welfare shown in "Attachment C: Schedule of Benefits" used to aid in the correction of vision, including but not limited to, lenses, lens options, frames and contact lenses.
120. **Well Woman Exam** – A routine visit every Annual Benefit Period to a Provider. The visit may include Medically Necessary and Medically Appropriate mammogram and cervical cancer screenings.

Attachment A: Covered Services and Exclusions

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

To be eligible for benefits, all services or supplies must be provided in accordance with this EOC, applicable medical policies, third-party clinical guidelines adopted by BlueCross and the Plan's Utilization Policies. See the "Prior Authorization, Care Management, Medical Policy and Patient Safety" section for more information.

This attachment sets forth Covered Services and exclusions (services not Covered). An item or service, to be a Covered Service, must not be illegal or unlawful when rendered by the Provider.

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

Please also read "Attachment B: Other Exclusions."

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

Out-of-Network Providers do not have a contract with the Plan. Except when prohibited by law, they may be able to charge You more than the Maximum Allowable Charge (the amount set by the Plan in its contracts with Network Providers). When You use an Out-of-Network Provider for Covered Services, You may be responsible for any unpaid Billed Charges. **This means that You may owe the Out-of-Network Provider a large amount of money, depending on the nature of the Covered Services rendered.**

All services and supplies not listed as a Covered Service in this EOC or not in accordance with applicable medical policies, third-party clinical guidelines adopted by BlueCross and the Plan's Utilization Policies may result in a reduction in reimbursement for otherwise eligible Covered Services.

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

When more than one (1) treatment alternative exists, each is Medically Appropriate and Medically Necessary, and each would meet Your needs, We reserve the right to provide payment for the least expensive Covered Service alternative.

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

A. Ambulance Services

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

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

B. Behavioral Health Services

Medically Necessary and Medically Appropriate Behavioral Health Services performed by a licensed Provider.

1. Prior Authorization may be required for:
    a. All inpatient levels of care, which include Acute care and residential care.
    b. Partial hospitalization programs.
    c. Intensive outpatient treatment programs.
    d. Certain outpatient Behavioral Health Services including, but not limited to, transcranial magnetic stimulation (TMS), applied behavioral analysis (ABA) therapy and psychological testing.

    Visit bcbst.com/PriorAuthorization or call the Member Service number on the back of Your Member ID card if You have questions about Prior Authorization requirements for Behavioral Health Services.

2. Covered Services
    a. Inpatient services for care and treatment of mental health and substance use disorders.
    b. Outpatient facility services, including partial hospitalization and intensive outpatient treatment programs for treatment of mental health and substance use disorders.
    c. Practitioner visits for care and treatment of mental health and substance use disorders.
    d. Medication Assisted Treatment (MAT), including drugs used for substance use disorder administered or dispensed directly by a Practitioner.
    e. Telehealth.
3. Exclusions
    a. Marriage and family counseling without a behavioral health diagnosis.
    b. Vocational and educational training and/or services.
    c. Custodial Care or domiciliary care.
    d. Treatment for conditions without recognizable ICD code classification, such as adult child of alcoholics (ACOA), and co-dependency and self-help programs.

C. Dental Services – Medically Necessary for all Members

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

1. Covered Services
    a. Dental services and oral surgical care to treat head and neck cancer, or to treat accidental injury to the jaw, sound natural teeth, mouth or face due to external trauma. The Surgery and services to treat accidental injury must be started within three (3) months and completed within twelve (12) months of the accident.

b. For dental services not listed in subsection a. above, general anesthesia, nursing and related hospital expenses in connection with an inpatient or outpatient dental procedure are Covered only when one (1) of the five (5) conditions listed below is met. **Prior Authorization for inpatient services is required.**

   i. Complex oral Surgical Procedures that have a high probability of complications due to the nature of the Surgery;

   ii. Concomitant systemic disease for which the patient is under current medical management and that significantly increases the probability of complications;

   iii. Mental health disorder or intellectual and developmental disability that precludes dental Surgery in the office;

   iv. Use of general anesthesia and the Member's medical condition requires that such procedure be performed in a hospital; or

   v. Dental treatment or Surgery performed on a Member eight (8) years of age or younger, where such procedure cannot be safely provided in a dental office setting.

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

2. Exclusions

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

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

c. Extraction of impacted teeth, including wisdom teeth. However, if both Your medical and dental plans are insured through BlueCross under the same Group number, this medical plan will pay secondary benefits for extraction of impacted teeth after Your BlueCross dental plan has paid its benefits.

D. Dental Services - Orthodontia - Pediatric Only

Medically Necessary and Medically Appropriate orthodontia for Members through the end of the month in which they turn nineteen (19).

1. Covered Services

a. Medically Necessary and Medically Appropriate non-Cosmetic orthodontia for Members through the end of the month in which they turn nineteen (19).

2. Exclusions
    a. Orthodontia for Members after the end of the month in which they turn nineteen (19) and older.
    b. Cosmetic orthodontia.

E. Dental Services – Pediatric Dental

This section provides a wide range of benefits to Cover most services associated with dental care for Members through the end of the month in which they turn nineteen (19).

If a Member transfers from the care of one (1) Dentist to another during the course of treatment, or if more than one (1) Dentist renders services for one (1) dental procedure, benefits will not exceed those that would have been provided had one (1) Dentist rendered the service.

When more than one (1) treatment alternative exists, meets generally accepted standards of professional dental care, and offers a favorable prognosis for Your condition, We reserve the right to provide payment for the least expensive Covered Service alternative.

I. **Diagnostic Services**

A. **Exams**

1. Covered Services
    a. Two (2) periodic, limited oral evaluation, comprehensive, detailed/extensive or periodontal exams in any twelve (12) month period.

B. **X-rays**

1. Covered Services
    a. One (1) full mouth set of x-rays in any sixty (60) month period. A full mouth set of x-rays is defined as either an intraoral complete series or panoramic x-ray. Benefits provided for either include benefits for all necessary intraoral and bitewing films taken on the same day.
    b. Up to four (4) bitewing films in any six (6) month period. All bitewing films must be taken on the same date of service.
    c. Intraoral periapical x-rays.
2. Exclusions
    a. Extraoral, skull and bone survey, sialography, and tomographic survey x-ray films, cephalometric films and diagnostic photographs.

II. **Preventive Services**

A. **Prophylaxis (Cleanings)**

1. Covered Services
    a. Two (2) prophylaxes in any twelve (12) month period, except when replaced as described below in Basic Periodontics.

B. **Fluoride Treatment**

1. Covered Services

   a. One (1) fluoride treatment in any six (6) month period.

C. **Other Preventive Services**

1. Covered Services

   a. One (1) sealant or preventive resin restoration per thirty-six (36) months on first and second permanent molars.

   b. Space maintainers.

   c. One (1) recementation per space maintainer in any twelve (12) month period.

   d. Palliative (Emergency) treatment for the relief of pain.

III. **Basic Restorative Services**

A. **Fillings and Stainless Steel Crowns**

1. Covered Services

   a. One (1) amalgam or resin restoration per tooth surface in any twelve (12) month period.

   b. Replacement of existing amalgam and resin composite restorations Covered only after twelve (12) months from the date of initial restoration.

   c. Stainless steel crowns

   d. Replacement of stainless steel crowns Covered only after sixty (60) months from the date of initial restoration.

   e. One (1) sealant, preventive resin restoration, or resin infiltration per first or second permanent molar tooth per thirty-six (36) months.
   Sealant/preventive resins are subject to additional limitations listed under Preventive Services, and may be subject to a different Coverage level under "Attachment C: Schedule of Benefits."

2. Exclusions

   a. Gold foil restorations.

B. **Other Basic Restorative Services**

1. Covered Services

   a. Crown and inlay re-cementation.

   b. General anesthesia or intravenous (IV) sedation in connection with a Covered Surgical Procedure when provided by a Dentist licensed to administer such agents.

c. One (1) repair per denture or bridge in any twenty four (24) month period.

d. One (1) denture adjustment in any six (6) month period and only after six (6) months from the date of initial placement.

e. One (1) denture reline, rebase or tissue conditioning in any thirty six (36) month period.

IV. **Major Restorative and Prosthodontic Services**

A. **Single Tooth Restorations**

1. Covered Services

a. Crowns (resin, porcelain, ¾ cast, and full cast), inlays and onlays (metallic, resin and porcelain) only for the treatment of severe carious lesions or severe fracture on permanent teeth, and only when teeth cannot be adequately restored with an amalgam or resin composite restoration (filling). Replacement of single tooth restorations or fixed partial dentures (bridges) after sixty (60) months from the date of initial placement.

b. Veneers for anterior permanent teeth.

2. Exclusions

a. Provisional restorations and crowns.

B. **Multiple Tooth Restorations – Bridges**

1. Covered Services

a. Fixed partial dentures (bridges), including pontics, retainers, and abutment crowns, inlays and onlays (resin, porcelain, ¾ and full cast) for permanent teeth only.

b. Replacement of fixed partial dentures or single tooth restorations after sixty (60) months from the date of initial placement.

2. Exclusions

a. Provisional or interim restorations.

C. **Removable Prosthodontics (Dentures)**

1. Covered Services

a. Complete, immediate and partial dentures for permanent teeth utilizing standard techniques and materials as determined by the Plan.

b. Personalized restoration, special techniques or materials shall be Covered up to the amount allowed for standard techniques or materials.

c. Replacement of removable dentures after sixty (60) months from the date of initial placement.

2. Exclusions

a. Interim (temporary) dentures.

D. **Other Major Restorative and Prosthodontic Services**

1. Covered Services

a. Core build-up Covered separately from restoration only in those circumstances where benefits are provided because severe carious lesions or fractures are so extensive that retention of the restoration would not be possible.

b. Crown inlay, onlay, veneer and bridge repair and re-cementation after twelve (12) months from the date of initial placement.

c. One (1) implant per tooth per sixty (60) months.

d. One (1) bone graft for implant per tooth per sixty (60) months.

e. One (1) implant debridement per tooth per sixty (60) months.

f. Initial placement or replacement of implant supported prosthesis after sixty (60) months from the date of any corresponding major restoration.

g. Occlusal guards by report for extreme bruxism (grinding) and other occlusal factors once every twelve (12) months for members age thirteen (13) to nineteen (19).

2. Exclusions

a. Provisional and interim restorations.

b. Other major restorative services including protective restoration and coping.

c. Other prosthodontic services including overdenture, precision attachments, connector bars, stress breakers and coping metal.

d. Crown preparation, temporary or prefabricated crowns, impressions and cementation.

e. Post and core services not performed in conjunction with a Covered crown or bridge.

V. **Endodontics (Treatment of the Dental Pulp or Root Canal)**

A. **Basic Endodontics**

1. Covered Services

a. Pulpotomy and pulpal therapy for primary teeth but not when performed in conjunction with major endodontic treatment.

2. Exclusions

a. Pulpal debridement.

b. Pulp vitality tests.

c. Protective restorations.

B. **Major Endodontics**

1. Covered Services

a. Root canal treatment (root canal, re-treatment, apexification, pulpal regeneration, root amputation, hemisection, and pulp cap).

b. Apicoectomy.

c. Retrograde filling if done on the same date of service as an apicoectomy.

2. Exclusions

a. Guided tissue regeneration.

b. Intentional reimplantation (including necessary splinting).

c. Canal preparation.

d. Incomplete endodontic therapy.

e. Pulp vitality test.

f. Protective restorations.

VI. **Periodontics**

A. **Basic Periodontics**

1. Covered Services

a. One (1) periodontal scaling and root planing per quadrant in any twenty four (24) month period.

b. One (1) full mouth debridement per lifetime.

c. Up to four (4) of any prophylaxis (cleaning) or periodontal maintenance procedure in any twelve (12) month period.

d. Periodontal maintenance no sooner than ninety (90) days after completion of any one of the Basic Periodontic Covered Services above. Periodontal maintenance will replace a prophylaxis or scaling.

e. Scaling in the presence of generalized moderate or severe gingival inflammation – full mouth, once per lifetime. Scaling will replace a prophylaxis or periodontal maintenance procedure.

2. Exclusions

a. Provisional splinting, antimicrobial medication and dressing changes.

b. Periodontal scaling and root planing, full mouth debridement, periodontal maintenance and prophylaxis when more than one of these procedures is performed on the same date of service.

B. **Major Periodontics**

1. Covered Services
    a. One (1) major surgical periodontal procedure per quadrant including gingivectomy, gingivoplasty, gingival flap procedure or osseous Surgery in any thirty six (36) month period.
    b. One (1) crown lengthening per tooth in any thirty six (36) month period.
    c. One (1) bone and tissue grafting per site in any thirty six (36) month period.
2. Exclusions
    a. Tissue regeneration and apically positioned flap procedure.

VII. **Oral Surgery**

A. **Basic Oral Surgery**

1. Covered Services
    a. Non-surgical or simple extractions (pulling teeth).

B. **Major Oral Surgery**

1. Covered Services
    a. Surgical extractions (including removal of impacted teeth), coronectomy, and other oral Surgical Procedures typically not Covered under a medical plan.
2. Exclusions
    a. Oral Surgery typically Covered under a medical plan including, but not limited to, excision of lesions and bone tissue, treatment of fractures, suturing, wound and other repair procedures.
    b. Harvesting of bone for use in autogenous grafting.

VIII. **General Pediatric Dental Exclusions**

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

A. Services rendered by a Dentist beyond the scope of his or her license.

B. Dental services which are free, or for which You are not required or legally obligated to pay or for which no charge would be made if You had no dental coverage.

C. Dental services covered by any medical insurance coverage, or by any other non-dental contract or certificate issued by BlueCross or any other insurance company, carrier, or plan. For example, removal of impacted teeth, tumors of lip and gum, accidental injuries to the teeth, etc.

D. Dental care or treatment not specifically listed in “Attachment C: Schedule of Benefits.”

E. Any treatment or service that the Plan determines (1) is not Necessary Dental Care; (2) does not offer a favorable prognosis; (3) does not meet generally accepted standards of professional dental care; or (4) is experimental in nature.

F. Charges for any hospital or other surgical or treatment facility and any additional fees charged by a Dentist for treatment in any such facility, except as otherwise Covered in this dental section.

G. Dental services with respect to congenital malformations or primarily for Cosmetic or aesthetic purposes including Cosmetic orthodontia.

H. Replacement of tooth structure lost from wear or attrition.

I. Dental services resulting from loss or theft of a denture, crown, bridge or removable orthodontic appliance.

J. Charges for a prosthetic device that replaces one (1) or more lost, extracted or congenitally missing teeth before Your Coverage becomes effective under the Plan unless it also replaces one (1) or more natural teeth extracted or lost after Your Coverage became effective.

K. Diagnosis for, or fabrication of, adjustment or maintenance and cleaning of maxillofacial prosthesis, appliances or restorations necessary to correct bite problems or restore the occlusion.

L. Diagnostic dental services such as diagnostic tests, image capture only and oral pathology services (except as stated elsewhere in this EOC).

M. Adjunctive dental services including all local and general anesthesia, sedation and analgesia (except as provided under a Covered Surgery).

N. Charges for the treatment of desensitizing medicaments, drugs, occlusal adjustments, mouthguards, microabrasion, behavior management and bleaching.

O. Additional charges for the treatment of professional visits outside the dental office or after regularly scheduled hours or for observation.

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

Q. Dental consultations including but not limited to reevaluations, nutritional and tobacco counseling, and oral hygiene instruction.

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

Medically Necessary and Medically Appropriate services, performed by a doctor of dental Surgery (DDS), a doctor of medical dentistry (DMD) or any Practitioner licensed to perform dental-related oral Surgery, to diagnose and treat temporomandibular joint syndrome or dysfunction (TMJ or TMD).

1. Covered Services

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

2. Exclusions

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

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

G. Diabetes Treatment

Medically Necessary and Medically Appropriate diagnosis and treatment of diabetes. In order to be Covered, such services must be prescribed and certified by a Practitioner as Medically Necessary. The treatment of diabetes consists of medical equipment, supplies, and outpatient self-management training and education, including nutritional counseling. See the "Drugs – Prescription Coverage" and "Vision – Medically Necessary for all Members" sections for additional diabetic benefits.

1. Covered Services

   a. Insulin pumps, infusion devices and appurtenances. Insulin pump replacement is Covered only for pumps older than forty-eight (48) months and if the pump cannot be repaired.

   b. Podiatric appliances for prevention of complications associated with diabetes.

2. Exclusions

   a. Treatments or supplies that are not prescribed and certified by a Practitioner as being Medically Necessary.

   b. Mandated Diabetic Supplies not identified by Tennessee state law.

   c. Duplicate podiatric appliances.

   d. Non-adjunctive continuous glucose monitors and related supplies not received through Your Pharmacy benefit.

H. Diagnostic Services

Medically Necessary and Medically Appropriate diagnostic radiology services and laboratory tests. Prior Authorization is required for certain Advanced Radiological Imaging services; if Prior Authorization is not obtained, benefits will be reduced.

1. Covered Services

   a. Imaging services ordered by a Practitioner, including x-ray, ultrasound, bone density test, and Advanced Radiological Imaging services.

   b. Diagnostic laboratory services ordered by a Practitioner.

2. Exclusions

   a. Diagnostic services not ordered by a Practitioner.

I. Drugs – Prescription Coverage

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

1. Covered Services

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

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

   b. Prescription Drugs, Mandated Diabetic Supplies and continuous glucose monitors and related supplies as listed on the Drug Formulary.

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

      i. Dispensed by a licensed pharmacist or dispensing Practitioner on or after the date Your Coverage begins;

      ii. Approved for use by the Food and Drug Administration (FDA); and

      iii. Listed on the Drug Formulary.

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

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

   f. Immunizations administered at a Network Pharmacy.

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

   If You abuse or overuse Pharmacy services outside of Our administrative procedures, We will work with You to select a Network Pharmacy, and You can request a change in Your Network Pharmacy.

2. Exclusions
    a. Drugs that are prescribed, dispensed or intended for use while You are confined in a hospital, skilled nursing facility or similar facility, except as otherwise Covered in this EOC.
    b. Prescription Drugs dispensed in a Practitioner's office, except as otherwise Covered in this EOC.
    c. Any Prescription Drug that exceeds Quantity Limits specified by the Plan's P&T Committee.
    d. Any Prescription Drug purchased outside the United States, except those Authorized by Us.
    e. Any Prescription Drug dispensed by or through a non-retail internet Pharmacy.
    f. Contraceptives that require administration or insertion by a Provider (e.g., non-drug devices, implantable products), except as otherwise Covered in this EOC.
    g. Medications intended to terminate a pregnancy.
    h. Non-medical supplies or substances, including support garments, regardless of their intended use.
    i. Artificial appliances.
    j. Allergen extracts.
    k. Prescription Drugs You receive without charge in accordance with any workers' compensation laws or any municipal, state, or federal program.
    l. Replacement Prescriptions resulting from lost, spilled, stolen or misplaced medications (except as required by applicable law).
    m. Prescription Drugs used for the treatment of infertility.
    n. Prescription Drugs not on the Drug Formulary.
    o. Anorectics (any drug or medicine for the purpose of weight loss and appetite suppression).
    p. All newly FDA-approved drugs prior to review by the Plan's P&T Committee. Prescription Drugs that represent an advance over available therapy according to the P&T Committee will be reviewed within at least six (6) months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug, will be reviewed within at least twelve (12) months after FDA approval.
    q. Any Prescription Drug used for the treatment of sexual dysfunction including, but not limited to, erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido.

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

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

t. Drugs used to enhance athletic performance.

u. Experimental and/or Investigational Drugs.

v. Prescription Drugs that are illegal under state or federal law such as marijuana.

w. Any Prescription Drugs dispensed more than one (1) year following the date of the Prescription, unless otherwise specified by Tennessee or federal law.

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

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

z. Any drugs, medications, Prescription devices, dietary supplements or vitamins available over-the-counter without a Prescription are not Covered, except as required by Tennessee or federal law.

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

bb. Narcotics (including opioids), psychoactive drugs (including benzodiazepines) and any other controlled substance prescribed by Providers that We have suspended or removed from Our network(s) due to abusive prescribing of such a drug or drugs.

3. Pharmacy Exception Requests

a. Standard exception request: If a clinically appropriate Prescription Drug is not included in Our Drug Formulary, You may contact Us by phone, electronically or in writing to request Coverage of that specific Prescription Drug or Specialty Drug. A standard exception request may be initiated by You, Your designee, or the prescribing Practitioner by calling Our consumer advisors at the Member Service number on the back of Your Member ID card or visiting bcbst.com/RxException. We will respond to a standard exception request no later than seventy-two (72) hours after the receipt date of the request. As part of the standard exception request, the prescribing Practitioner should include an oral or written statement that provides justification to support the need for the Prescription Drug not included in Our Drug Formulary to treat the Member's condition, if all other reasonable and appropriate resources have been exhausted, and including a statement that all Covered Prescription Drugs in Our Drug Formulary on any tier:

i. Will be or have been ineffective;

ii. Would not be as effective as the Prescription Drug not included in Our Drug Formulary; or

iii. Would have adverse effects.

If We grant a standard exception request for Coverage of a Prescription Drug that is not in Our Drug Formulary, We will Cover the Prescription Drug for the duration of the Prescription, including refills. Any applicable cost sharing (such as Copayment or Coinsurance) for the Prescription will apply toward the Out-of-Pocket Maximum. If We deny a standard exception request, You have the right to an independent review of Our decision, as described below in subsection “c. External exception request."

b. Expedited exception request: If a clinically appropriate Prescription Drug is not included in Our Drug Formulary, an expedited exception request based on exigent circumstances may be initiated by You, Your designee, or Your prescribing Practitioner by calling Our consumer advisors at the Member Service number on the back of Your Member ID card or visiting bcbst.com/RxException. We will respond to an expedited exception request within twenty-four (24) hours of receipt of the request. An exigent circumstance exists when a Member is:

i. Suffering from a health condition that may seriously jeopardize their life, health, or ability to regain maximum function; or

ii. Undergoing a current course of treatment using a Prescription Drug not included in Our Drug Formulary.

As part of the expedited review request, the prescribing Practitioner should include an oral or written statement:

i. That an exigent circumstance exists and explain the harm that could reasonably be expected to the Member if the requested Prescription Drug is not provided within the timeframes of the standard exception request process as outlined above in subsection “a. Standard exception request”; and

ii. That has justification supporting the need for the Prescription Drug not included in Our Drug Formulary to treat the Member's condition, including a statement that:

1. All Covered Prescription Drugs in Our Drug Formulary on any tier will be or have been ineffective;

2. Would not be as effective as the Prescription Drug not included in Our Drug Formulary; or

3. Would have adverse effects.

If We grant an expedited exception based on exigent circumstances for Coverage of the Prescription Drug that is not in Our Drug Formulary, We will provide access to the Prescription Drug:

i. Without unreasonable delay; and

ii. For the duration of the exigent circumstance.

Any applicable cost sharing (such as Copayment or Coinsurance) for the Prescription will apply toward the Out-of-Pocket Maximum. If We deny an expedited exception request, You have the right to an independent review of Our decision, as described below in subsection "c. External exception request."

c. External exception request: If We deny a request for a standard exception or an expedited exception, You, Your designee, or the prescribing Practitioner may initiate an external exception request for the original exception request and the denial of that request to be reviewed by an independent review panel. The independent review panel's decision to either uphold or reverse the denial of the original exception request will be provided orally or in writing to You, Your designee, or the prescribing Practitioner no later than:

i. Twenty-four (24) hours after receipt of an external exception review request if the original exception request was expedited; or

ii. Seventy-two (72) hours after receipt of an external exception review request if the original exception request was standard.

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

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

J. Durable Medical Equipment (DME)

Medically Necessary and Medically Appropriate medical equipment or items that (1) in the absence of illness or injury, are of no medical or other value to You; (2) can withstand repeated use in an ambulatory or home setting; (3) require a Prescription; (4) are approved by the FDA for the illness or injury for which it is prescribed; and (5) are not solely for Your Convenience. Prior Authorization is required for certain DME; If Prior Authorization is not obtained, benefits will be reduced.

1. Covered Services

a. Rental of DME - Maximum allowable rental charge not to exceed the total Maximum Allowable Charge for purchase. If You rent the same type of equipment from multiple DME Providers, and the total rental charges from the multiple Providers exceed the purchase price of a single piece of equipment, You will be responsible for amounts in excess of the Maximum Allowable Charge for purchase.

b. DME that meets the medical need for which it was requested, whether that be safety, assistance with activities of daily living, or support of bodily functions.

c. The repair, adjustment or replacement of components and accessories necessary for the effective functioning of Covered DME.

d. Supplies and accessories necessary for the effective functioning of Covered DME.

e. The replacement of items needed as the result of normal wear and tear, defects or obsolescence and aging. Insulin pump replacement is Covered only for pumps older than forty-eight (48) months and only if the pump cannot be repaired.

2. Exclusions

a. Charges exceeding the total cost of the Maximum Allowable Charge to purchase the equipment.

b. Duplicate equipment.

c. Supplies and accessories that are not necessary for the effective functioning of the Covered equipment.

d. Items to replace those that were lost, damaged, stolen or prescribed as a result of new technology except when the new technology is replacing items as a result of normal wear and tear, defects or obsolescence and aging.

e. Items that require or are dependent on alteration of home, workplace or transportation vehicle.

f. Motorized scooters, exercise equipment, hot tubs, pools and saunas.

g. Additional components or upgrades for appearance or functions not directly related to the medical need.

h. Computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs and seat lifts of any kind.

i. Patient lifts, auto tilt chairs, air fluidized beds or air flotation beds, unless approved by the Utilization Management department.

j. Portable ramp for a wheelchair.

K. Emergency Care Services

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

To avoid extra cost, which could be substantial, You should utilize a Network Provider.

If You go to a Network Provider, You will receive the highest level of benefits for Covered Services and may not be billed for amounts over Your Deductible and Out-of-Pocket Maximum, which limits Your liability. Not all Providers are in Your network. Please log in at bcbst.com/Findaprovider to see all the Providers in Your network, or call the Member Service number on the back of Your Member ID card.

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

1. Covered Services
    a. Medically Necessary and Medically Appropriate Emergency Care Services, supplies and medications necessary for the diagnosis and stabilization of Your Emergency condition. In certain cases, Emergency Care Services may include items and services after the Member is stabilized and as part of outpatient observation or an inpatient or outpatient stay related to the Emergency.
    b. Practitioner services.

An observation stay and/or Surgery that occurs in conjunction with an Emergency Room (ER) visit may be subject to Member cost share under the "Outpatient Facility Services" section of "Attachment C: Schedule of Benefits," in addition to Member cost share for the ER visit.

2. Exclusions
    a. Treatment of a chronic, non-Emergency condition, where the symptoms have existed over a period of time, and a prudent layperson who possesses an average knowledge of health and medicine would not believe it to be an Emergency.
    b. Services received for inpatient care or transfer to another facility once Your medical condition has stabilized, unless Prior Authorization is obtained from the Plan within two (2) business days from the inpatient admission.

L. Family Planning and Reproductive Services

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

1. Covered Services
    a. Benefits for (1) family planning; (2) history; (3) physical examination; (4) diagnostic testing until infertility treatment begins; and (5) genetic testing for family planning.
    b. Sterilization procedures.
    c. Services or supplies for the evaluation of infertility.
    d. Medically Necessary and Medically Appropriate termination of a pregnancy.
    e. Injectable and implantable contraceptives and vaginal barrier methods including initial fitting, insertion and removal.
2. Exclusions
    a. Services or supplies that are designed to create a pregnancy, enhance fertility or improve conception quality including, but not limited to, (1) artificial insemination; (2) in vitro fertilization; (3) fallopian tube reconstruction; (4) uterine reconstruction; (5) assisted reproductive technology (ART) including, but not limited to, gamete and zygote intrafallopian transfer (GIFT and ZIFT); (6) fertility injections; (7) fertility drugs; and (8) services for follow-up care related to infertility treatments.
    b. Services or supplies for the reversals of sterilizations.

c. Induced abortion unless (1) permissive under applicable law and (2) one or more of the following circumstances exists: (i) the abortion was necessary to prevent the death of the Member or to prevent serious risk of substantial harm to the Member, (ii) the fetus is not viable, (iii) the pregnancy is the result of rape or incest, or (iv) the fetus has been diagnosed with a lethal or otherwise significant abnormality. We reserve the right to request that Providers submit an attestation certifying the abortion is in compliance with any and all applicable state and federal laws.

M. Hearing Aids

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

1. Covered Services

   a. The initial purchase of Covered Hearing Aids, limited as indicated in "Attachment C: Schedule of Benefits."

   b. The repair, adjustment or replacement of components and accessories necessary for the effective functioning of Covered equipment, except as otherwise indicated under Exclusions.

2. Exclusions

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

   b. Items to replace those that were lost, damaged or stolen.

   c. Items prescribed as a result of new technology.

N. Home Health Care Services

Medically Necessary and Medically Appropriate services and supplies provided in Your home by a Practitioner who is primarily engaged in providing home health care services. Home health visits may require Prior Authorization. Physical, speech or occupational therapy services provided in the home apply to the therapy services visit limits shown in "Attachment C: Schedule of Benefits." If multiple therapies are provided during the same home visit, each therapy will count toward the separate visit limit for that type of therapy.

1. Covered Services

   a. Part-time, intermittent health services, supplies and medications, by or under the supervision of a registered nurse.

   b. Home infusion therapy.

   c. Therapies, subject to the limitations of the "Therapeutic/Rehabilitative/Habilitative Services" section.

   d. Medical social services.

   e. Dietary guidance.

f. Coverage may be limited as indicated in “Attachment C: Schedule of Benefits.”

2. Exclusions

a. Items such as non-treatment services for (1) routine transportation; (2) homemaker or housekeeping services; (3) supportive environmental equipment; (4) Custodial Care; (5) social casework; (6) meal delivery; (7) personal hygiene; (8) Convenience Items; (9) private duty nursing; and (10) home health aides.

O. Hospice

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

Prior Authorization for inpatient hospice must be obtained from the Plan or benefits will be reduced.

1. Covered Services

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

2. Exclusions

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

P. Inpatient Acute Care Hospital Services

Medically Necessary and Medically Appropriate services and supplies in a hospital that (1) is licensed as an Acute care institution; (2) provides inpatient services; (3) has surgical and medical facilities primarily for the diagnosis and treatment of a disease or injury; and (4) has a staff of physicians licensed to practice medicine and provides twenty-four (24) hour nursing care. Psychiatric hospitals are not required to have a surgical facility.

Prior Authorization for Covered Services (except maternity, initial admission only, and Emergency admissions) must be obtained from the Plan, or benefits will be reduced.

1. Covered Services

a. Room and board; general nursing care; medications; injections; diagnostic services; and special care units.

b. Attending Practitioner’s services for professional care.

c. Maternity and delivery services (including routine nursery care and Complications of Pregnancy). If the hospital or physician provides services to the baby and submits a claim in the baby’s name, benefits may be Covered for the baby and mother as

separate Members, requiring payment of applicable Member Copayments, Coinsurance and/or Deductibles.

2. Exclusions

   a. Inpatient stays for services for conditions that don't require intensity of care and services, and/or specialty care that can be performed outside of an Acute care setting.

   b. Private duty nursing.

   c. Services that could be provided in a less-intensive setting.

   d. Blood or plasma provided at no charge to the patient.

Q. Organ Transplants

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

1. Prior Authorization

   Transplant Services require Prior Authorization. Transplant Services that have not received Prior Authorization will not be Covered.

2. Benefits

   Transplant benefits are different than benefits for other services.

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

   You have access to three levels of benefits:

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

   b. **Transplant Network:** If You want to receive the maximum benefit, You should use a facility in the BDCT Network. If You instead have a transplant performed at a facility in the Transplant Network (non-BDCT), the Plan will pay at the benefit level listed in "Attachment C: Schedule of Benefits" for the Transplant Network. Travel expenses for Transplant Services are Covered only if You go to a facility in

the BDCT Network; see the Travel Expenses section for benefits. **Not all Network Providers are in the Transplant Network. Please check with the Transplant Case Management department to determine if the Transplant Network is the best network available for Your specific transplant type.**

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

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

3. Covered Services

Benefits are payable for the following transplants if deemed Medically Necessary and Medically Appropriate and Prior Authorization is obtained:

a. Pancreas.

b. Pancreas/Kidney.

c. Kidney.

d. Liver.

e. Heart.

f. Heart/Lung.

g. Lung.

h. Bone marrow or stem cell transplant (allogeneic and autologous) for certain conditions.

i. Small bowel.

j. Multi-organ transplants as deemed Medically Necessary.

k. Organ and tissue procurement, as indicated below.

l. Travel expenses for Transplant Services, as indicated below.

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

4. Organ and Tissue Procurement

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

a. Donor search.

b. Testing for donor's compatibility.

c. Removal of the organ/tissue from the donor's body.

d. Preservation of the organ/tissue.

e. Transportation of the tissue/organ to the site of transplant.

f. Donor follow-up care directly related to the organ donation, except as otherwise indicated under Exclusions.

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

5. Travel Expenses for Transplant Recipients

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

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

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

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

   i. Lodging expenses are limited to $50 per person per day.

   ii. Meals are only Covered when provided at the facility where the Covered person is receiving inpatient medical care.

c. The aggregate limit for travel expenses, including meals and lodging, is $10,000 per Covered transplant.

For full details on available travel expenses, visit bcbst.com/tml to review Our administrative services policy.

6. Travel Expenses for Live Kidney Donors

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

Covered travel expenses must be approved by the Transplant Case Management department and include travel to and from the transplant facility for the kidney donation procedure and required pre-testing and post-donation follow-up care.

a. Covered travel expenses will not apply to the Deductible or Out-of-Pocket Maximum if donor is a Member.

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

   i. Lodging expenses are limited to $50 per person per day.

   ii. Meals are only Covered when provided at the facility where the Covered person is receiving inpatient medical care.

c. The aggregate limit for travel expenses, including meals and lodging, is $5,000 per kidney donation.

For full details on available travel expenses, visit bcbst.com/tml to review Our administrative services policy.

7. Exclusions

   a. Any attempted Covered procedure that was not performed, except where such failure is beyond Your control.

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

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

   d. 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.

   e. 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.

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

   g. Other non-organ transplants (e.g., cornea) are not Covered under this section, but may be Covered as an Inpatient Acute Care Hospital Service or outpatient facility service, if Medically Necessary.

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

R. Outpatient Facility Services

Medically Necessary and Medically Appropriate diagnostics, therapies and Surgery occurring in an outpatient facility that includes (1) outpatient Surgery centers; (2) the outpatient center of a hospital; (3) outpatient diagnostic centers; and (4) certain surgical suites in a Practitioner's office. Prior Authorization is required for certain outpatient services; if Prior Authorization is not obtained, benefits will be reduced.

1. Covered Services
    a. Practitioner services.
    b. Outpatient diagnostics (such as x-rays and laboratory services).
    c. Outpatient treatments (such as medications and injections).
    d. Outpatient Surgery and supplies.
    e. Observation stays less than twenty-four (24) hours.
    f. Therapies, subject to the limitations of the "Therapeutic/Rehabilitative/Habilitative Services" section.
    g. Telehealth.
2. Exclusions
    a. Services that could be provided in a less-intensive setting.

S. Practitioner Office Services

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

1. Covered Services
    a. Diagnosis and treatment of illness or injury. Note that allergy skin testing is Covered only in the Practitioner office setting. RAST (radioallergosorbent test), FAST (fluorescent allergosorbent test), or MAST (multiple radioallergosorbent test) is Covered in the Practitioner office setting and in a licensed laboratory.
    b. Injections and medications administered in a Practitioner's office, except Specialty Drugs. See the "Specialty Drugs" section for information on Coverage.
    c. Second surgical opinions given by a Practitioner who is not in the same medical group as the Practitioner who initially recommended Surgery.
    d. Therapies, subject to the limitations of the "Therapeutic/Rehabilitative/Habilitative Services" section.
    e. Preventive/Well care services.

        Preventive Health Exam and related services for adults and children in accordance with federal regulations, as outlined below and performed by the physician during the Preventive Health Exam or referred by the physician as appropriate, including, but not limited to:

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

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

iii. Preventive care and screening for women as provided in the guidelines supported by HRSA; and

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

f. Telehealth.

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

2. Exclusions

a. Routine foot care for the treatment of (1) flat feet; (2) corns; (3) bunions; (4) calluses; (5) toenails; (6) fallen arches; and (7) weak feet or chronic foot strain.

b. Dental procedures, except as otherwise indicated in this EOC.

c. Office visits and physical exams when required solely for participation in sports.

T. Prosthetics/Orthotics

Medically Necessary and Medically Appropriate devices used to correct or replace all or part of a body organ, body structure or limb that may be malfunctioning or missing due to (1) birth defect; (2) accident; (3) illness; or (4) Surgery. Prior Authorization is required for certain prosthetics and orthotics; if Prior Authorization is not obtained, benefits will be reduced. Hearing Aids are not considered to be prosthetics or orthotics; see the "Hearing Aid" section for benefits.

1. Covered Services

a. The initial purchase of surgically implanted prosthetic or orthotic devices, including cochlear implants.

b. The repair, adjustment or replacement of components and accessories necessary for the effective functioning of Covered equipment.

c. Splints and braces that are custom made or molded, and are incidental to a Practitioner's services or on a Practitioner's order.

d. The replacement of Covered items required as a result of normal wear and tear, defects or obsolescence and aging.

e. The initial purchase of artificial limbs or eyes.

2. Exclusions

a. Prosthetics primarily for Cosmetic purposes including, but not limited to, wigs, other hair prosthesis or hair transplants.

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

c. Foot orthotics, shoe inserts and custom-made shoes except as required by Tennessee or federal law for diabetic patients or as a part of a leg brace.

d. Duplicate equipment.

U. Reconstructive Surgery

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

Prior Authorization is required for certain Covered Services; if Prior Authorization is not obtained, benefits will be reduced.

1. Covered Services

   a. Surgery to correct significant defects from congenital causes, accidents or disfigurement from a disease state that result in functional impairment.

   b. Reconstructive breast Surgery as a result of a mastectomy or partial mastectomy (other than lumpectomy) including Surgery on the non-diseased breast needed to establish symmetry between the two breasts.

2. Exclusions

   a. Services, supplies or prosthetics primarily to improve appearance.

   b. Surgeries to correct or repair the results of a prior Surgical Procedure, the primary purpose of which was to improve appearance, and Surgeries to improve appearance following a prior Surgical Procedure, even if that prior procedure was a Covered Service.

   c. Cosmetic Services or Surgery – See “Attachment B: Other Exclusions.”

   d. Voice modification Surgery or voice therapy.

   e. Transportation, meals, lodging or similar expenses.

V. Skilled Nursing/Rehabilitative Facility Services

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

1. Covered Services

   a. Room and board, general nursing care, medications, diagnostics and special care units.

   b. The attending Practitioner’s services for professional care.

   c. Coverage is limited as indicated in the “Attachment C: Schedule of Benefits.”

   d. Therapy services such as physical and occupational therapy.

2. Exclusions
    a. Custodial Care, domiciliary or private duty nursing services.
    b. Skilled nursing services not received in a Medicare-certified skilled nursing facility.
    c. Inpatient neurocognitive therapy, unless it is provided in combination with other Medically Necessary treatment or therapy.

W. Specialty Drugs

Medically Necessary and Medically Appropriate Specialty Drugs used to treat chronic, complex conditions and that typically require special handling, administration or monitoring. Certain Specialty Drugs require Prior Authorization from the Plan, or benefits will be reduced. Call Our consumer advisors at the Member Service number on the back of Your Member ID card or visit bcbst.com/rx, to find out which Specialty Drugs require Prior Authorization.

1. Covered Services
    a. Provider-administered Specialty Drugs as identified on the Provider-administered Specialty Drug list when dispensed by a Pharmacy in Our Specialty Pharmacy Network. The current list is available for review at bcbst.com/rx.
    b. Self-administered Specialty Drugs as identified on the Drug Formulary when dispensed by a Pharmacy in Our Specialty Pharmacy Network. The Drug Formulary is available for review at bcbst.com/rx.
2. Exclusions
    a. FDA-approved drugs used for purposes other than those approved by the FDA, unless the drug is recognized for the treatment of the particular indication in one (1) of the standard reference compendia.
    b. Specialty Drugs filled or refilled at a Pharmacy not participating in the Specialty Pharmacy Network.

X. Supplies

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

1. Covered Services
    a. Supplies for the treatment of disease or injury used in a Practitioner's office, outpatient facility or inpatient facility.
    b. Supplies for treatment of disease or injury that are prescribed by a Practitioner and cannot be obtained without a Prescription.
2. Exclusions
    a. Supplies that can be obtained without a Prescription (except for diabetic supplies). Examples include, but are not limited to, (1) adhesive bandages; (2) dressing

material for home use; (3) antiseptics; (4) medicated creams and ointments; (5) cotton swabs; and (6) eyewash.

Y. Therapeutic/Rehabilitative/Habilitative Services

Medically Necessary and Medically Appropriate Rehabilitative Therapy and Habilitative Therapy services performed in a Practitioner's office, outpatient facility or home health setting and intended to enable a person with a disability to attain functional abilities, or to restore or improve bodily function lost as the result of Acute illness, Acute injury, autism spectrum disorder or congenital anomaly. Therapeutic/Rehabilitative/Habilitative services may require Prior Authorization. For Therapeutic/Rehabilitative/Habilitative services received in the home health setting, Home Health Care benefits will apply.

1. Covered Services
   a. Outpatient, home health or office Rehabilitative Therapy and Habilitative Therapy services. The services must be performed by, or under the direct supervision of a licensed therapist.
   b. Habilitative Therapy services include (1) physical therapy; (2) speech therapy; and (3) occupational therapy services.
   c. Rehabilitative Therapy services include (1) physical therapy; (2) speech therapy for restoration of speech; (3) occupational therapy; (4) spinal manipulation therapy; (5) cardiac and pulmonary rehabilitative services; and (6) acupuncture.
   d. Telehealth.
   e. Coverage is limited, as indicated in "Attachment C: Schedule of Benefits."
      i. The limit on the number of visits for therapy applies to all visits for that therapy, whether received in a Practitioner's office, outpatient facility or home health setting. If multiple therapies are provided during the same visit, each therapy will count toward the separate visit limit for that particular therapy.
      ii. Services received during an inpatient hospital, skilled nursing or rehabilitative facility stay are Covered as shown in the "Inpatient Acute Care Hospital Services" and "Skilled Nursing/Rehabilitative Facility Services" sections, and are not subject to the therapy visit limits.
2. Exclusions
   a. Enhancement therapy that is designed to improve Your physical status beyond Your pre-injury or pre-illness state.
   b. Complementary and alternative therapeutic services including, but not limited to, (1) massage therapy; (2) vision exercise therapy; and (3) craniosacral therapy.
   c. Modalities that do not require the attendance or supervision of a licensed therapist. These include, but are not limited to, (1) activities that are primarily social or recreational in nature; (2) simple exercise programs; (3) hot and cold packs applied in the absence of associated therapy modalities; (4) repetitive exercises or tasks that

You can perform without a therapist, in a home setting; (5) routine dressing changes; and (6) Custodial Care services that can ordinarily be taught to You or a caregiver.

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

Z. Urgent Care Center Services

Medically Necessary and Medically Appropriate treatment at an Urgent Care Center that is required to prevent serious deterioration of Your health and that is required as a result of an unforeseen illness or injury or the onset of Acute severe symptoms.

1. Covered Services
    a. Diagnosis for the treatment of illness or injury.
    b. Diagnostic services (such as x-rays and laboratory services).
    c. Injections and medications administered in an Urgent Care Center, except Specialty Drugs. See the "Specialty Drugs" section for information on Coverage.
    d. Surgery and supplies.
    e. Therapies, subject to the limitations of the "Therapeutic/Rehabilitative/Habilitative Services" section.
    f. Telehealth.

AA. Vision – Medically Necessary for all Members

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

1. Covered Services
    a. Services and supplies for the diagnosis and treatment of diseases and injuries to the eye.
    b. Frames, lenses and contacts following treatment and Surgery to repair certain injuries and diseases that impair vision.
        i. The first set of eyeglasses or contact lenses required to adjust for vision changes due to cataract Surgery and obtained within six (6) months following Surgery.
    c. One (1) retinopathy screening for diabetics per Annual Benefit Period.
2. Exclusions
    a. Routine vision services, including services, Surgeries and supplies to detect or correct refractive errors of the eyes.
    b. Eyeglasses, contact lenses and examinations for the fitting of eyeglasses and contact lenses.

c. Eye exercises and/or therapy.

d. Visual training.

e. The replacement of contacts after the initial pair has been provided following cataract Surgery.

BB. Vision – Pediatric Vision

This section provides benefits to Cover routine services associated with vision care for Members through the end of the month in which they turn nineteen (19). Plan benefits are based on the services and supplies described in this "Attachment A: Covered Services and Exclusions" and provided in accordance with the benefit schedules set forth in "Attachment C: Schedule of Benefits."

1. Covered Services

   a. One (1) Vision Examination per Annual Benefit Period.

   b. One (1) pair of eyeglass frames per Annual Benefit Period.

   c. One (1) set of eyeglass lenses, prescription sunglasses or contact lenses per Annual Benefit Period.

2. Exclusions

   a. Medical and/or surgical treatment of the eyes or supporting structure, including Surgeries to detect or correct refractive errors of the eyes.

   b. Refraction, when not provided as part of a Comprehensive Eye Examination.

   c. Eye exercises and/or therapy.

   d. Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; aniseikonic lenses.

   e. Charges for lenses and frames ordered while insured but not delivered within sixty (60) days after Coverage is terminated, or for vision testing examinations that occur after the date of termination.

   f. Charges filed for procedures determined by the Plan to be special or unusual (i.e. orthoptics, vision training, subnormal vision aids, aniseikonic lenses, tonography, corneal refractive therapy, etc.).

   g. Charges for lenses that do not meet the Z80.1 or Z80.2 standards of the American National Standards Institute.

   h. Charges in excess of the Covered benefit as established by the Plan.

   i. Oversized Lenses.

   j. Corrected eyewear required by an Employer as a condition of employment, and safety eyewear unless specifically Covered under this EOC.

   k. Non-Prescription lenses and frames, and non-Prescription sunglasses.

l. Two (2) pairs of glasses in lieu of bifocals.

m. Safety items or items to affect performance primarily in sports-related activities.

n. Charges for replacement of broken, lost, or stolen lenses, contact lenses or frames.

o. Charges for services or Vision Materials from an Ophthalmologist, Optometrist or Optician acting outside the scope of his or her license.

p. Charges for any additional service required outside basic vision analyses for contact lenses, except fitting fees.

Attachment B: Other Exclusions

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

1. Services or supplies not listed as Covered Services under "Attachment A: Covered Services and Exclusions."
2. Services or supplies that are determined to be not Medically Necessary and Medically Appropriate.
3. Services or supplies that are Investigational in nature including, but not limited to, (1) drugs; (2) biologicals; (3) medications; (4) devices; and (5) treatments.
4. Services or supplies provided by a Provider that is not accredited or licensed or are outside the scope of the Provider's license.
5. Illness or injury resulting from war, that occurred before Your Coverage began under this EOC and that is Covered by (1) veteran's benefit; or (2) other coverage for which You are legally entitled.
6. Self-treatment or training.
7. Staff consultations required by hospital or other facility rules.
8. Services rendered free of charge, except when rendered by a non-governmental, charitable research hospital that bills patients for services rendered but does not enforce collection from an individual patient.
9. Services or supplies for the treatment of work-related illness or injury, regardless of the presence or absence of workers' compensation coverage. This exclusion does not apply to injuries or illnesses of an Employee who is (1) a sole-proprietor of the Group, unless required by law to carry workers' compensation insurance; (2) a partner of the Group, unless required by law to carry workers' compensation insurance; or (3) a corporate officer of the Group, provided the officer filed an election not to accept workers' compensation with the appropriate government department.
10. Personal, physical fitness, recreational or Convenience Items, equipment and services, even if ordered by a licensed Practitioner including, but not limited to, weight loss programs and exercise programs; air conditioners, humidifiers, air filters and heaters; saunas, swimming pools and whirlpools; water purifiers; tanning beds; televisions; barber and beauty services; and self-help devices, programs or applications (including but not limited to mobile medical applications) of any type, whether for medical, behavioral health or non-medical use, unless such mobile application required by state or federal law or is approved in advance by BlueCross to be used in connection with a wellness program offered by BlueCross.
11. Services or supplies received before Your Effective Date for Coverage with this Plan.
12. Services or supplies related to a Hospital Confinement, received before Your Effective Date for Coverage with this Plan.

13. Services or supplies received after Your Coverage under this Plan ceases for any reason. This is true even though the expenses relate to a condition that began while You were Covered. The only exception to this is described under the “Extended Benefits” section.
14. Services or supplies received in a dental or medical department maintained by or on behalf of the Employer, mutual benefit association, labor union or similar group.
15. Services or charges to complete a claim form or to provide medical records or other administrative functions. We will not charge You or Your legal representative for statutorily required copying charges.
16. Charges for failure to keep a scheduled appointment.
17. Charges for telephone consultations, email or web-based consultations, except as otherwise stated in this EOC.
18. Room, board and general nursing care rendered on the date of discharge, unless admission and discharge occur on the same day.
19. Charges in excess of the Maximum Allowable Charge for Covered Services.
20. Any service stated in “Attachment A: Covered Services and Exclusions” as a non-Covered Service or limitation.
21. Charges for services performed by You or Your spouse, or Your or Your spouse’s parent, sister, brother or child.
22. Any charges for handling fees.
23. Safety items or items to affect performance primarily in sports-related activities.
24. Services or supplies, including bariatric Surgery, for weight loss or to treat obesity, even if You have other health conditions that might be helped by weight loss or reduction of obesity. This exclusion applies whether You are of normal weight, overweight, obese or morbidly obese.
25. Services that are Cosmetic and include, but not limited to, (1) removal of elective body art; (2) facelifts; (3) body contouring; (4) injections to smooth wrinkles; (5) piercing ears or other body parts; (6) rhytidectomy or rhytidoplasty; (7) brachioplasty; (8) keloid removal; (9) dermabrasion; (10) chemical peels; and (11) laser resurfacing.
26. Lipectomy for cosmetic purpose or for the treatment of variations in fat distribution.
27. Charges related to surrogate pregnancy when the surrogate mother is not a Covered Member under this Plan.
28. Sperm preservation.
29. Private duty nursing.
30. Unless Covered in the “Drugs – Prescription Coverage” section, services or supplies related to sexual dysfunction, regardless of cause, including, but not limited to, erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido. This exclusion does not apply to office visits.
31. Charges for injuries due to chewing or biting or received in the course of other dental procedures.

32. Services or supplies directly related to complications of Cosmetic procedures, complications of bariatric Surgery; re-operation of bariatric Surgery or body contouring with the intention of achieving an improved cosmetic appearance after weight loss.
33. Intradiscal annuloplasty to treat discogenic back pain.
34. Human growth hormones, unless Covered in the "Drugs – Prescription Coverage" section.
35. Prescription Drugs that are illegal under state or federal law such as marijuana.
36. Immunizations required for sports, camp, employment, insurance and marriage or legal proceedings.
37. Travel immunizations not received through Your Pharmacy benefit.
38. Compound Drugs, unless Medically Necessary and Medically Appropriate.
39. Intraoral devices for the treatment of headaches.
40. Medical tourism or care received outside the United States when You choose to have an elective procedure in another country.
41. Non-emergency and non-urgent medical services or supplies received while traveling outside of the United States when treatment could have been reasonably delayed.
42. Home delivery of childbirth and any related services, unless the delivery is performed by a provider licensed by the state board of nursing as a registered nurse, duly certified as a nurse midwife by the American College of Nurse-Midwives.
43. Devices and computers to assist in communication or speech (e.g., Dynavox).
44. Wilderness treatment programs, boarding school programs or similar programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution). This exclusion applies to programs that treat medical conditions, surgical conditions, behavioral health conditions and substance use disorder.
45. Services that do not require a licensed professional and may be provided by non-clinical personnel. This includes art therapy, music therapy, dance therapy, horseback therapy, and other forms of alternative treatment as defined by the National Center for Complementary and Integrative Health (NCCIH).
46. Virtual reality therapy services, devices and software.
47. Surgeries and related services and prescription medications for puberty blockers or hormones performed or administered on a Member under age 18, for purposes of gender dysphoria, gender identity disorder, gender incongruence, or similar conditions, unless such services or medications are (1) permissive under applicable law and the health care Practitioner submits an attestation regarding the same; and (2) Medically Necessary and Medically Appropriate. We reserve the right to request that Providers submit an attestation certifying the services in compliance with any and all applicable state and federal laws.

Attachment C: Schedule of Benefits

Group Name: Tony's Cee Bee, Inc.
Group Number: 112703
Effective Date: November 1, 2026
Network: Blue Network S

PLEASE READ THIS IMPORTANT STATEMENT: Network Benefits apply to Covered services received from Network Providers and Non-Contracted Providers. **Out-of-network benefit percentages apply to Our Maximum Allowable Charge, not to the Provider's Billed Charge, unless otherwise stated. When using Out-of-Network Providers or Non-Contracted Providers, the Member may be responsible for any unpaid Billed Charges. This amount can be substantial.**

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

1. Emergency Care Services rendered at an out-of-network hospital, Emergency department or a licensed independent freestanding Emergency department.
2. Covered items and services rendered by an Out-of-Network Provider at an in-network facility. In compliance with applicable state or federal law, You may agree to receive treatment for certain services from an Out-of-Network Provider and waive balance billing protections, provided that You provide consent prior to treatment, and that Your consent satisfies applicable regulatory requirements.
3. Emergent and other Authorized air ambulance services (the same criteria to determine if services from an in-network air ambulance Provider are Covered is used to determine whether services from an out-of-network air ambulance Provider are Covered).

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

For more information, please refer to the definitions of Coinsurance and Maximum Allowable Charge in the "Definitions" section of this EOC.

Covered Services	Network Providers	Out-of-Network Providers
Preventive Care		
Preventive/Well care services Includes: • Preventive Health Exam for adults or children, limited to one (1) per Annual Benefit Period • Well Woman Exam, limited to one (1) per Annual Benefit Period • Screenings, including, but not limited to, screenings with an A or B recommendation by the United States Preventive Services Task Force (USPSTF), Bright Futures recommendations for infants, children and adolescents supported by the Health Resources and Services Administration (HRSA), and screenings for women as provided in the guidelines supported by HRSA. Examples include, but are not limited to, screenings for breast cancer, cervical cancer, prostate cancer, colorectal cancer, high cholesterol and sexually transmitted infections • Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC) • Preventive counseling services with an A or B recommendation by the United States Preventive Services Task Force (USPSTF) • Tobacco use counseling performed in a primary care setting, limited to eight (8) visits per Annual Benefit Period • Alcohol misuse counseling performed in a primary care setting, limited to eight (8) visits per Annual Benefit Period • Dietary counseling for adults with hyperlipidemia, hypertension, obesity, type 2 diabetes, coronary artery disease and/or congestive heart failure, limited to twelve (12) visits per Annual Benefit Period	100%	50% of the Maximum Allowable Charge after Deductible

Covered Services	Network Providers	Out-of-Network Providers
Lactation support services by a licensed Provider during pregnancy or in the postpartum period	100%	50% of the Maximum Allowable Charge after Deductible
Breast pump, limited to one (1) per pregnancy, and related supplies	100%	50% of the Maximum Allowable Charge after Deductible
FDA-approved contraceptive methods, sterilization procedures and counseling for women with reproductive capacity	100%	50% of the Maximum Allowable Charge after Deductible
Screening colonoscopy or screening flexible sigmoidoscopy For non-screening colonoscopy or sigmoidoscopy benefits, see **Office Surgery** under the **Practitioner Office Visits** section or **Outpatient Facility Services/Outpatient Surgery** section of this schedule.	100%	50% of the Maximum Allowable Charge after Deductible
One (1) retinopathy screening for diabetics per Annual Benefit Period	100%	Not Covered
Hemoglobin A1C Test	100%	50% of the Maximum Allowable Charge after Deductible
Practitioner Office Visits (Excluding Preventive Care)		
Diagnosis and treatment of illness or injury, including medical and behavioral health conditions	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
Maternity care - initial office visit to confirm pregnancy	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
Allergy testing	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
Allergy injections and allergy extract	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
All other medicine injections, excluding Specialty Drugs For Surgery injections, please see **Office Surgery** under the **Practitioner Office Visits** section of this schedule.	100% after Deductible	50% of the Maximum Allowable Charge after Deductible

Covered Services	Network Providers	Out-of-Network Providers
Office Surgery, including anesthesia, performed in and billed by the Practitioner's office Surgeries include incisions, excisions, biopsies, injection treatments, fracture treatments, applications of casts and splints, sutures, and invasive diagnostic services (e.g., colonoscopy, sigmoidoscopy and endoscopy for non-preventive purposes). Prior Authorization is required for some procedures. See the "Prior Authorization, Care Management, Medical Policy and Patient Safety" section of this EOC for more information.	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
Non-routine treatments including renal dialysis, radiation therapy, chemotherapy and infusions Does not apply to Specialty Drugs. See **Provider-administered Specialty Drugs** section of this schedule for applicable benefit.	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
Supplies	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
Services Received at a Facility		
Prior Authorization is required for inpatient hospital stays (except maternity, initial admission only, and Emergency admissions), inpatient Behavioral Health Services, skilled nursing facility or rehabilitation facility stays and for certain outpatient facility procedures. Call Our consumer advisors to determine if Prior Authorization is required before receiving either inpatient or outpatient facility services. **See the "Prior Authorization, Care Management, Medical Policy and Patient Safety" section of this EOC for more information.**		
Inpatient Hospital Stays, Including Inpatient and Residential Care Behavioral Health Services and Maternity Stays		
Facility charges	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
Practitioner charges, including global maternity delivery charges billed as inpatient services	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
Advanced Radiological Imaging services Includes CT scans, MRIs, PET scans, nuclear medicine and similar technologies	100% after Deductible	50% of the Maximum Allowable Charge after Deductible

Covered Services	Network Providers	Out-of-Network Providers
Skilled Nursing or Rehabilitation Facility Stays Limited to sixty (60) days combined per Annual Benefit Period		
Facility charges	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
Practitioner charges	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
Outpatient Facility Services, Including Behavioral Health Intensive Outpatient and Partial Hospitalization Programs **Outpatient Surgery** Surgeries include invasive diagnostic services (e.g., colonoscopy, sigmoidoscopy and endoscopy for non-preventive purposes).		
Facility charges	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
Practitioner charges	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
Supplies	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
All other services received at an outpatient facility, including behavioral health intensive outpatient and partial hospitalization programs, observation stays, chemotherapy, radiation therapy, infusions and renal dialysis	100% after Deductible	50% of the Maximum Allowable Charge after Deductible

Covered Services	Network Providers	Out-of-Network Providers
Emergency Care Services **Benefits listed are for Emergency situations only.** Non-Emergency use of out-of-network Emergency Care Services may apply the out-of-network Deductible. For more information, please refer to the definitions of Emergency and Emergency Care Services in the "Definitions" section of this EOC.		
Emergency Room (ER) charges An observation stay and /or Surgery that occurs in conjunction with an ER visit may be subject to Member cost share under the **Outpatient Facility Services** section of this schedule in addition to Member cost share for the ER visit.	$500 Copay, then 100% after Deductible	$500 Copay, then 100% of the Maximum Allowable Charge after Network Deductible
Advanced Radiological Imaging services Includes CT scans, MRIs, PET scans, nuclear medicine and similar technologies	100% after Deductible	100% of the Maximum Allowable Charge after Network Deductible
All other hospital charges	100% after Deductible	100% of the Maximum Allowable Charge after Network Deductible
Practitioner charges	100% after Deductible	100% of the Maximum Allowable Charge after Network Deductible
Urgent Care		
Urgent Care Center charges	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
Other Services (Any Place of Service)		
Advanced Radiological Imaging services Includes CT scans, MRIs, PET scans, nuclear medicine and similar technologies Prior Authorization is required for certain Advanced Radiological Imaging services, except when performed as part of an Emergency care visit. See the "Prior Authorization, Care Management, Medical Policy and Patient Safety" section of this EOC for more information.	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
All other diagnostic services for illness, injury or maternity care	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
Supplemental breast screenings and related diagnostic imaging consisting of mammography, ultrasound imaging or magnetic resonance imaging	100%	50% of the Maximum Allowable Charge after Deductible

Covered Services	Network Providers	Out-of-Network Providers
Therapy services – Rehabilitative[4] Limited per Annual Benefit Period as follows: • 20 physical therapy visits • 20 speech therapy visits • 20 occupational therapy visits • 20 spinal manipulation therapy visits • 20 acupuncture therapy visits • 36 cardiac rehab therapy visits • 36 pulmonary rehab therapy visits Limits do not apply to services for treatment of autism spectrum disorders. Prior Authorization may be required. See the "Prior Authorization, Care Management, Medical Policy and Patient Safety" section of this EOC for more information.	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
Therapy services – Habilitative[4] Limited per Annual Benefit Period as follows: • 20 physical therapy visits • 20 speech therapy visits • 20 occupational therapy visits Limits do not apply to services for treatment of autism spectrum disorders. Prior Authorization may be required. See the "Prior Authorization, Care Management, Medical Policy and Patient Safety" section of this EOC for more information.	100% after Deductible	50% of the Maximum Allowable Charge after Deductible

Covered Services	Network Providers	Out-of-Network Providers
Home health care services, including home infusion therapy Physical, speech or occupational therapy services provided in the home apply to the therapy services visit limits. If multiple therapies are provided during the same home visit, each therapy will count toward the separate visit limit for that particular therapy.[4] Prior Authorization may be required. See the "Prior Authorization, Care Management, Medical Policy and Patient Safety" section of this EOC for more information.	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
Durable medical equipment (DME), orthotics and prosthetics, including DME supplies Prior Authorization may be required for certain DME, orthotics or prosthetics. See the "Prior Authorization, Care Management, Medical Policy and Patient Safety" section of this EOC for more information.	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
Hearing Aids limited to one (1) per ear every three (3) years as determined by Your Annual Benefit Period Prior Authorization may be required. See the "Prior Authorization, Care Management, Medical Policy and Patient Safety" section of this EOC for more information.	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
Sleep studies Prior Authorization may be required. See the "Prior Authorization, Care Management, Medical Policy and Patient Safety" section of this EOC for more information.	100% after Deductible	50% of the Maximum Allowable Charge after Deductible

Covered Services	Network Providers	Out-of-Network Providers
Ambulance services – Ground Prior Authorization may be required for certain ground ambulance services. See the "Prior Authorization, Care Management, Medical Policy and Patient Safety" section of this EOC for more information.	100% after Deductible	100% of the Maximum Allowable Charge after Deductible
Ambulance services – Air Prior Authorization may be required for certain air ambulance services. See the "Prior Authorization, Care Management, Medical Policy and Patient Safety" section of this EOC for more information.	100% after Deductible	100% of the Maximum Allowable Charge after Deductible
Hospice care Prior Authorization is required for inpatient stays. See the "Prior Authorization, Care Management, Medical Policy and Patient Safety" section of this EOC for more information.	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
Teladoc consultations via phone, tablet or computer See the "Health and Wellness" section of this EOC for more information.	100%	Not Covered

Organ Transplant Services			
Covered Services	**Blue Distinction Centers for Transplants (BDCT) Network**	**Transplant Network (Non-BDCT)**	**Out-of-Network Providers**
All Transplant Services All Transplant Services require Prior Authorization. Contact Our Transplant Case Management department before any pre-transplant evaluation or other Transplant Service is performed to request Prior Authorization and to determine if there are facilities available in the BDCT Network for Your specific transplant type. See the "Prior Authorization, Care Management, Medical Policy and Patient Safety" and "Organ Transplants" sections of this EOC for more information.	100% after Deductible	100% after Deductible	50% of the Maximum Allowable Charge after Deductible

Prescription Drugs for Retail Network and Home Delivery Network Refer to the **Essential Drug Formulary** at bcbst.com/rx for a list of covered drugs.				
Prescription Drugs[1,2,5]	**Generic Drug**	**Preferred Brand Drug**	**Non-Preferred Brand Drug**	**Out-of-Network[3]**
RX03 Retail Network – Up to a thirty (30) day supply	100% after Deductible	100% after Deductible	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
RX03 Retail Network – Greater than a thirty (30) day supply	Not Covered; must utilize either **Home Delivery Network or Plus90 Retail Network**			
Home Delivery Network and Plus90 Retail Network – Up to a thirty (30) day supply	100% after Deductible	100% after Deductible	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
Home Delivery Network and Plus90 Retail Network – For a thirty-one (31) to sixty (60) day supply	100% after Deductible	100% after Deductible	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
Home Delivery Network and Plus90 Retail Network – For a sixty-one (61) to ninety (90) day supply	100% after Deductible	100% after Deductible	100% after Deductible	50% of the Maximum Allowable Charge after Deductible

Self-Administered Specialty Drugs – To receive benefits for self-administered Specialty Drugs, You must use a Specialty Pharmacy Network Provider. For information on benefits for Provider-administered Specialty Drugs, please refer to the "Specialty Drugs" section of this EOC. Self-administered Specialty Drugs are limited up to a thirty (30) day supply per Prescription.		
Self-Administered Specialty Drugs[1,2]	**Specialty Pharmacy Network**	**Out-of-Network[6]**
Self-administered Specialty Drugs, as indicated in Our Essential Drug Formulary	100% after Deductible	Not Covered

Provider-Administered Specialty Drugs – To receive benefits for Provider-administered Specialty Drugs, You must use a Specialty Pharmacy Network Provider. Cost share listed for Provider-administered Specialty Drugs is for the medication only. Providers may bill additional charges for administering the drug; refer elsewhere in the schedule for applicable benefit (e.g. chemotherapy, lab work). At the Specialty Pharmacy Network, You will pay the lesser of Your applicable Copay or Coinsurance, the Maximum Allowable Charge, Our discounted rate or the Specialty Pharmacy Network's charge for the Specialty Drug.		
Provider-administered Specialty Drugs[2]	**Specialty Pharmacy Network**	**Out-of-Network[6]**
Provider-administered Specialty Drugs, as indicated in the Provider-administered Specialty Drug list	100% after Deductible	Not Covered

Pediatric Dental		
Covered Services	**Network Dentists**	**Out-of-Network Dentists**
Coverage A: Diagnostic and preventive services: exams; cleanings; x-rays Limited to two (2) visits every twelve (12) months	100%	100% of the Maximum Allowable Charge
Coverage B: Basic and restorative services: basic restorative; basic endodontics; oral Surgery; basic periodontics	80%	80% of the Maximum Allowable Charge
Coverage C: Major restorative and prosthodontic services: major restorative; major endodontics; major periodontics; implants	50%	50% of the Maximum Allowable Charge
Coverage D: Medically Necessary orthodontia	100% after Deductible	50% of the Maximum Allowable Charge after Deductible

Pediatric Vision		
Covered Services	**Network Providers**	**Out-of-Network Providers**
One (1) Vision Examination, including dilation as necessary per Annual Benefit Period	100%	60% of the Maximum Allowable Charge
Contact Lens Fit and Follow-Up Contact lens fit and two (2) follow-up visits are available once a Vision Examination has been completed.		
Standard contact lens fit and follow-up	100%	60% of the Maximum Allowable Charge
Premium contact lens fit and follow-up		
Frames: Provider-designated frames available at the Provider's location	100%	60% of the Maximum Allowable Charge
Standard Lenses (Glass or Plastic):		
Single vision	100%	60% of the Maximum Allowable Charge
Bifocal		
Trifocal		
Lenticular		
Standard progressive lens		
Lens Options:		
UV treatment	100%	60% of the Maximum Allowable Charge
Tint (fashion & gradient & glass-grey)		
Standard plastic scratch Coating		
Standard polycarbonate		
Photochromic/Transitions plastic		
Contact Lenses: Provider-designated contact lenses available at the Provider's location Contact lens includes materials only		
Extended wear and extended wear disposables Up to six (6) month supply of monthly or two (2) week disposable, single vision spherical contact lenses	100%	60% of the Maximum Allowable Charge
Daily wear/disposables Up to three (3) month supply of daily disposable, single vision spherical contact lenses		

Deductible and Out-of-Pocket Maximum	Network Services	Out-of-Network Services
Deductible		
Individual	$7,400	$14,800
Family	$7,400 per Member, not to exceed $14,800 for all Covered Family Members	$14,800 per Member, not to exceed $29,600 for all Covered Family Members
Out-of-Pocket Maximum		
Individual	$7,400	$22,200
Family	$7,400 per Member, not to exceed $14,800 for all Covered Family Members	$22,200 per Member, not to exceed $44,400 for all Covered Family Members
Annual Benefit Period	January 1 - December 31	

1. For both Prescription Drugs and self-administered Specialty Drugs, if You or the prescribing physician choose a Preferred Brand Drug or Non-Preferred Brand Drug when a Generic Drug equivalent is available, You will be financially responsible for the Non-Preferred Brand Drug Copay or Coinsurance plus a Penalty. The Penalty is the difference between the cost of the Preferred Brand Drug or Non-Preferred Brand Drug and the Generic Drug.
2. Some products may be subject to Quantity Limits, Step Therapy and Prior Authorizations specified by the Plan's P&T Committee.
3. If You have a Prescription filled at an Out-of-Network Pharmacy, You must pay all expenses and file a claim for reimbursement with Us. Reimbursement is based on the Maximum Allowable Charge, less any applicable out-of-network Deductible, Coinsurance and/or Copay amount.
4. Visit limits for each therapy type represent the maximum available per Annual Benefit Period, regardless of type/extent of injury, condition or number of episodes requiring therapy.
5. At the Network Pharmacy, You will pay the lesser of Your applicable Copay or Coinsurance, the Maximum Allowable Charge, Our discounted rate or the Network Pharmacy's charge for the Prescription Drug.
6. Out-of-Network refers to outside the Specialty Pharmacy Network, not outside the standard Retail Network.

Attachment D: Eligibility

Any Employee of the Group and his/her family dependents, who meet the eligibility requirements of this section, will be eligible for Coverage under the Group Agreement if properly enrolled for Coverage and upon payment of the required Premium for such Coverage. If there is any question about whether a person is eligible for Coverage, the Employer shall make final eligibility determinations in accordance with the requirements of this EOC and the Group Agreement. At the Group or Employer's request, this plan may not cover spouses or dependent children. Check with Your benefits representative for full details. If You qualify as a retiree, You may still be an eligible Employee under this EOC after You leave employment. Check with Your benefits representative for full details.

A. Subscriber

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

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

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

B. Covered Dependents

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

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

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

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

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

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

C. Loss of Eligibility

Coverage for a Member who has lost his/her eligibility shall automatically terminate at 12:00 midnight on the day that loss of eligibility occurred.