

Evidence of Coverage

Health Benefit Plan



WFI-(CDHP Plan)

West Fraser, Inc. **CDHP**
Group Number 125225
January 1, 2015

NOTICE

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

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

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INTRODUCTION

This Evidence of Health Coverage (this “EOC”) is included in the Summary Plan Description document (SPD) created by the Employer (listed on the cover of this EOC) as part of its employee welfare benefit plan (the “Plan”), and is subject to the requirements of the Employee Retirement Income Security Act of 1974, as amended (ERISA). References in this EOC to “administrator,” “We,” “Us,” “Our,” or “BlueCross” mean BlueCross BlueShield of Tennessee, Inc. The Employer has entered into an Administrative Services Agreement (ASA) with BlueCross for it to administer the claims Payments under the terms of the SPD, and to provide other services. BlueCross does not assume any financial risk or obligation with respect to Plan claims. BlueCross is not the Plan Sponsor, the Plan Administrator or the Plan Fiduciary, as those terms are defined in ERISA. The Employer is the Plan Fiduciary, the Plan Sponsor and the Plan Administrator. To the extent applicable, the Plan complies with federal requirements.

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

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

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

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

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

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

BENEFIT ADMINISTRATION ERROR

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

NOTIFICATION OF CHANGE IN STATUS

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

- name;
- address;
- telephone number;

- employment; or
- status of any other health coverage You have.

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

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

WHAT IS A HIGH DEDUCTIBLE HEALTH PLAN?

The Company's Consumer Driven Health Plan (CDHP) is a High Deductible Health Plan, which has a higher Calendar Year Deductible than a typical health plan. Most services are Covered only after You meet Your Deductible. Some preventive care benefits may be paid before the Deductible is satisfied. See Attachment C: Schedule of Benefits.

How do Deductibles work with a CDHP?

If You have Subscriber only health Coverage (also called Self-Only Coverage) under this CDHP plan, You must meet the Self-Only Deductible before any benefits will be paid under the Plan.

If You have Coverage for Yourself and one or more family Members under this CDHP plan, You and the family Members must satisfy the full Family Deductible before any benefits will be paid on any family Member.

Some preventive care benefits may be paid before the Deductible is satisfied. See Attachment C: Schedule of Benefits.

ELIGIBILITY

Any Employee of the Employer and his or her family dependents who meet the eligibility requirements of this Section will be eligible for Coverage if properly enrolled for Coverage. If there is any question about whether a person is eligible for Coverage, the Plan shall make final eligibility determinations.

A. Subscriber

To be eligible to enroll as a Subscriber, an Employee must:

1. Be an Employee of the Employer, who is Actively at Work; and
2. Satisfy all eligibility requirements of the Plan; and
3. Enroll for Coverage from the Plan as outlined by the Employer.

B. Covered Dependents

To be eligible to enroll as a Covered Dependent, a Member must meet all dependent eligibility criteria established by the Employer, and be:

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

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

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

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

The Plan reserves the right to require proof of eligibility including, but not limited to, a certified copy of any Qualified Medical Child Support Order.

C. Lay-off/Rehire Provision

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

D. Domestic Partner

The term spouse may also include a Domestic Partner as defined by the Employer.

Once a person qualifies as the Domestic Partner of a Subscriber, the children of that Domestic Partner who otherwise meet the Employer's requirements for eligible children will be eligible.

ENROLLMENT IN THE PLAN

Eligible Employees may enroll for Coverage for themselves and their eligible dependents as set forth in this section. No person is eligible to re-enroll if the Plan previously terminated his or her Coverage for cause.

A. Initial Enrollment Period

Eligible Employees may enroll for Coverage for themselves and their eligible dependents within the first 31 days of employment.

B. Open Enrollment Period

Eligible Employees shall be entitled to apply for Coverage for themselves and eligible dependents during their Employer's Open Enrollment Period. Employees who become eligible for Coverage other than during an Open Enrollment Period may apply for Coverage for themselves and eligible dependents within 31 days of becoming eligible for Coverage, or during a subsequent Open Enrollment Period.

C. Adding Dependents

A Subscriber 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, and a legally adopted child, or a child 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 that child within 31 days of the date that the Subscriber acquires the child.

If the Subscriber fails to do so, and an additional Payment is required to cover a newborn or newly acquired child, the Plan will not provide Coverage for that child after 31 days from the date the Subscriber or the Subscriber's spouse acquired the child.

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

2. If the legally adopted (or placed) child has Coverage of his or her medical expenses from a public or private agency or entity, the Subscriber may not add the child until that coverage ends. Any other new dependent, (e.g., if the Subscriber marries) may be added as a Covered Dependent if the Subscriber enrolls the dependent within 31 days of the date that person first becomes eligible for Coverage.
3. The Subscriber or the Subscriber's eligible dependent who did not apply for Coverage within 31 days of first becoming eligible for Coverage under this Plan may enroll if:
 - a. The Subscriber or the Subscriber's eligible dependent had other health care coverage at the time Coverage under this Plan was previously offered; and
 - b. such other coverage is exhausted (if the other coverage was continuation coverage under COBRA) or the other coverage was terminated because the Subscriber or the Subscriber's eligible dependent ceased to be eligible due to involuntary termination or Employer contributions for such coverage ended; and
 - c. The Subscriber or the Subscriber's eligible dependent applies for Coverage under this Plan within 31 days after the loss of the other coverage.

D. Late Enrollment

Employees or their dependents who do not enroll when becoming eligible for Coverage, as shown above, may enroll:

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

E. Enrollment upon Change in Status

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

1. You must request the change within 31 days of the change in status for the following events: (1) marriage or divorce; (2) death of the Employee's spouse or dependent; (3) change in dependency status; (4) Medicare eligibility; (5) coverage by another Payor; (6) birth or adoption of a child of the Employee; (7) termination of employment, or commencement of employment, of the Employee's spouse; (8) switching from part-time to full-time, or from full-time to part-time status by the Employee or the Employee's spouse; (9) taking an unpaid leave of absence by the Employee or the Employee's spouse, or returning from unpaid leave of absence; (10) significant change in the health coverage of the Employee or the Employee's spouse attributable to the spouse's employment.
2. You must request the change within 60 days of the change in status for the following events: (1) loss of eligibility for Medicaid or CHIP coverage, or (2) becoming eligible to receive a subsidy for Medicaid or CHIP coverage.

WHEN COVERAGE BEGINS

If You are eligible, and have enrolled, 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 ASA

Coverage shall be effective on the effective date of the ASA, if all eligibility requirements are met as of that date; or

B. Enrollment During an Open Enrollment Period

Coverage shall be effective on the first day of the plan year following the Open Enrollment Period; or

C. Enrollment During an Initial Enrollment Period

Coverage shall be effective on the date of hire; or

D. Newly Eligible Employees

Coverage shall be effective on the date of eligibility as specified in the ASA; or

E. Newly Eligible Dependents

1. Dependents acquired as the result of Employee's marriage – Coverage will be effective on the day of the marriage;
2. Newborn children of the Employee or Employee's spouse - Coverage will be effective as of the date of birth;
3. Dependents adopted or placed for adoption with Employee – 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, as set out in the "Enrollment" section; or

F. Actively at Work Rule

If an eligible Employee is not Actively at Work on the date Coverage would otherwise become effective, Coverage for the Employee and all his or 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 BlueCross or the Employer

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

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

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 Employer and the administrator during the term of the ASA. Coverage for a Member who has lost his or her eligibility shall automatically terminate at 12:00 midnight on the last day of the month during which that loss of eligibility occurred.

C. Termination of Coverage for Cause

The Plan may terminate Your Coverage for cause if:

1. You fail to make a required Member payment when it is due. (The fact that You have made a Payment contribution to the Employer will not prevent the administrator from terminating Your Coverage if the Employer fails to submit the full Payment for Your Coverage to the administrator when due); or
2. You fail to cooperate with the Plan or Employer as required; or
3. You have made a material misrepresentation or committed fraud against the Plan. This provision includes, but is not limited to, furnishing incorrect or misleading information or permitting the improper use of the membership ID card.

D. Right to Request a Hearing

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

E. Payment For Services Rendered After Termination of Coverage

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

F. Extended Benefits

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

CONTINUATION OF COVERAGE

Federal Law

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

A. Eligibility

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

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

B. Enrolling for COBRA Continuation Coverage

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

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

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

C. Payment

You must submit any Payment required for COBRA Continuation Coverage to the administrator at the address indicated on Your Payment notice. If You do not enroll when first

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

D. Coverage Provided

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

E. Duration of Eligibility for COBRA Continuation Coverage

COBRA Continuation Coverage is available for a maximum of:

1. 18 months if the loss of Coverage is caused by termination of employment or reduction in hours of employment; or
2. 29 months of Coverage. If, as a qualified beneficiary who has elected 18 months of COBRA Continuation Coverage, You are determined to be disabled within the first 60 days of COBRA Continuation Coverage, You can extend Your COBRA Continuation Coverage for an additional 11 months, up to 29 months. Also, the 29 months of COBRA Continuation Coverage is available to all non-disabled qualified beneficiaries in connection with the same qualifying event. "Disabled" means disabled as determined under Title II or XVI of the Social Security Act. In addition, the disabled qualified beneficiary or any other non-disabled qualified beneficiary affected by the termination of employment qualifying event must.
 - a. Notify the Employer or the administrator of the disability determination within 60 days after the determination of disability, and before the close of the initial 18-month Coverage period; and
 - b. Notify the Employer or the administrator within 30 days of the date of a final determination that the qualified beneficiary is no longer disabled; or
3. 36 months of Coverage if the loss of Coverage is caused by:
 - a. the death of the Subscriber;
 - b. loss of dependent child status under the Plan;
 - c. the Subscriber becomes entitled to Medicare; or
 - d. divorce or legal separation from the Subscriber; or
4. 36 months for other qualifying events. If a Covered Dependent is eligible for 18 months of COBRA Continuation Coverage as described above, and there is a second qualifying event (e.g., divorce), You may be eligible for 36 months of COBRA Continuation Coverage from the date of the first qualifying event.

F. Termination of COBRA Continuation Coverage

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

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

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

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

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

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

H. Continued Coverage During a Military Leave of Absence

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

I. The Trade Adjustment Assistance Reform Act of 2002

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

PRIOR AUTHORIZATION, CARE MANAGEMENT, MEDICAL POLICY AND PATIENT SAFETY

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

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

A. Prior Authorization

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

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

- *Out-of-Network Inpatient Hospital and Inpatient Hospice stays (except maternity admissions)*
- *Out-of-Network Skilled nursing facility and rehabilitation facility admissions*
- *Out-of-Network Inpatient Hospital and Inpatient Hospice stays (except maternity admissions)*
- *Inpatient treatment for Behavioral Health Services*
- *Certain Outpatient Surgeries and/or procedures*
- *Advanced Radiological Imaging services*
- *Out-of-Network Durable Medical Equipment (DME) greater than \$500.00*
- *Prosthetics*
- *Orthotics*
- *Spinal surgeries*
- *Spinal injections*
- *Hip, knee, and shoulder surgeries*
- *Transplantation Services*

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

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

Network Providers in Tennessee will request Prior Authorization for You.

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

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

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

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

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

The Member is not held harmless if:

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

B. Care Management

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

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

Lifestyle Coaching - inspires, engages, and guides individuals to make lasting changes in their lives to improve their health and well-being. Through this voluntary program, You have access to a personal health assessment and personal wellness report, and a wellness portal filled with interactive health trackers and resources, as well as self-directed programs designed to support and motivate You to take charge of Your health. You also have unlimited access to Your dedicated lifestyle health coach. Communicate with Your coach via secure email or phone. Your lifestyle health coach can work with you on weight loss or weight management, improving nutrition, optimizing fitness, stress management, blood pressure management, cholesterol management, and tobacco cessation. To speak with a lifestyle health coach, call toll free 1-866-498-9806.

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

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

PRECIOUS CARGO ^(SM) PROGRAM - Precious Cargo ^(SM) is a healthy baby program available through the Employer. Through it, You receive special information and services for mothers-to-be who enroll in this prenatal health education program. To enroll, call 1-800-395-BABY (1-800-395-2229).

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

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

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

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

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

C. Medical Policy

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

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

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

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

D. Patient Safety

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

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.

INTER-PLAN PROGRAMS

A. Out-of-Area Services

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

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

1. BlueCard® PPO Program

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Member Liability Calculation

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

b. Exceptions

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

4. BlueCard Worldwide® Program

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

CLAIMS AND PAYMENT

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

A. Claims

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

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

B. Claims Billing

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

4. You may request a claim form from Our customer service department. We will send You a claim form within 15 days. You must submit proof of payment acceptable to Us with the claim form. We may also request additional information or documentation if it is reasonably necessary to make a Coverage decision concerning a claim.
5. A Network Provider or an Out-of-Network Provider may refuse to render a service, or reduce or terminate a service that has been rendered, or require You to pay for what You believe should be a Covered Service. If this occurs:
 - a. You may submit a claim to Us to obtain a Coverage decision concerning whether the Plan will Cover that service. For example, if a pharmacy (1) does not provide You with a prescribed medication; or (2) requires You to pay for that prescription, You may submit a claim to the Plan to obtain a Coverage decision about whether it is Covered by the Plan.
 - b. You may request a claim form from Our customer service department. We will send You a claim form within 15 days. We may request additional information or documentation if it is reasonably necessary to make a Coverage decision concerning a claim.
6. Providers may bill or charge for Covered Services differently. Network Providers are reimbursed based on Our agreement with them. Different Network Providers have different reimbursement rates for different services. Your Out-of-Pocket expenses can be different from Provider to Provider.

C. Payment

1. If You received Covered Services from a Network Provider, the Plan will pay the Network Provider directly. These payments are made according to Our agreement with that Network Provider. You authorize assignment of benefits to that Network Provider. Covered Services will be paid at the Network Benefit level.
2. If You received Covered Services from an Out-of-Network Provider, You must submit, in a timely manner, a completed claim form for Covered Services. If the claim does not require further investigation, the Plan will reimburse You. The Plan may make payment for Covered Services either to the Provider or to You, at its discretion. The Plan's payment fully discharges its obligation related to that claim.
3. Non-Contracted Providers may or may not file Your claims for You. Either way, the Network Benefit level shown in Attachment C: Schedule of Benefits will apply to claims for Covered Services received from Non-Contracted Providers. However, You are responsible for the difference in the Billed Charge and the Maximum Allowable Charge for that Covered Service. The Plan's payment fully discharges its obligation related to that claim.
4. If the ASA is terminated, all claims for Covered Services rendered prior to the termination date, must be submitted to the Plan within 1 year and 90 days from the date the Covered Services were received.
5. We will pay benefits according to the Plan within 30 days after We receive a claim form that is complete. Claims are processed in accordance with current industry standards, and based on Our information at the time We receive the claim form. Neither the Plan nor We are responsible for over or under payment of claims if Our information is not complete or is inaccurate. We will make reasonable efforts to obtain and verify relevant facts when claim forms are submitted.

6. When a claim is paid or denied, in whole or part, We will produce an Explanation of Benefits (EOB). This will describe how much was paid to the Provider, and also let You know if You owe an additional amount to that Provider. The administrator will make the EOB available to You at www.bcbst.com, or by calling the customer service department at the number listed on Your membership ID card.
7. You are responsible for paying any applicable Copayments, Coinsurance, or Deductible amounts to the Provider. If We pay such amounts to a healthcare provider on Your behalf, We may collect those cost-sharing amounts directly from You.

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

D. Complete Information

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

Mail all claim forms to:

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

COORDINATION OF BENEFITS

This EOC includes the following Coordination of Benefits (COB) provision, which applies when a Member has coverage under more than one group contract or health care "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 be increased because of this provision.

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

A. Definitions

The following terms apply to this provision:

1. "Plan" means any form of medical or dental coverage with which coordination is allowed. "Plan" includes:
 - a. group, blanket, or franchise insurance;
 - b. a group BlueCross Plan, BlueShield Plan;
 - c. group or group-type coverage through HMOs or other prepayment, group practice and individual practice plans;
 - d. coverage under labor management trust Plans or employee benefit organization Plans;
 - e. coverage under government programs to which an employer contributes or makes payroll deductions;
 - f. coverage under a governmental Plan or coverage required or provided by law;
 - g. medical benefits coverage in group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type coverages;
 - h. coverage under Medicare and other governmental benefits; and
 - i. any other arrangement of health coverage for individuals in a group.
2. "Plan" does not include individual or family:
 - a. Insurance contracts;
 - b. Subscriber contracts;
 - c. Coverage through Health Maintenance (HMO) organizations;
 - d. Coverage under other prepayment, group practice and individual practice plans;
 - e. Public medical assistance programs (such as TennCareSM);
 - f. Group or group-type hospital indemnity benefits of \$100 per day or less;
 - g. School accident-type coverages.

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

3. "This Plan" refers to the part of the employee welfare benefit plan 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 another 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 Plan or Plans.

5. "Allowable Expense" means a necessary, reasonable and customary item of expense 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. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition, unless the patient's stay in a private hospital room is Medically Necessary, either in terms of generally accepted medical practice, or as specifically defined in the Plan.
- c. We will determine only the benefits available under This Plan. You are responsible for supplying Us with information about Other Plans so We can act on this provision.

6. "Claim Determination Period" means a Calendar Year. 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 which 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:
 - (1) benefits of the Plan of an active Employee covering the person as a Dependent;

- (2) Medicare;
- (3) 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 another 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 has covered one parent longer are determined before those of the Plan that has 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, the Plans do not agree on the order of benefits, the rule in the Other Plan will determine the order of benefits.

3. Dependent Child/Separated or Divorced 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 in Paragraph 2(b), 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 are determined before those of a Plan which covers that person as a laid off or retired Employee. If the Other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Rule is ignored.

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 24 hours after the first ended.
- b. The start of the new Plan does not include:
 - (1) A change in the amount or scope of a Plan's benefits;
 - (2) A change in the entity that pays, provides, or administers the Plan's benefits; or
 - (3) 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.

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.

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."

Rules. 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:
 - (1) The Non-complying Plan reduces its benefits so that the 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
 - (2) Governing state law allows the right of subrogation set forth below;then the Complying Plan shall advance to You or on Your behalf an amount equal to such difference. However, in no event shall the Complying Plan

advance more than the Complying Plan would have paid, had it been the Primary Plan, less any amount it previously paid. In consideration of such advance, the Complying Plan shall be subrogated to all Your rights against the Non-complying Plan. Such advance by the Complying Plan shall also be without prejudice it may have against the Non-complying Plan in the absence of such subrogation.

C. Effect on the Benefits of this Plan

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

1. Benefits of This Plan will be reduced when the sum of:
 - a. the benefits that would be payable for the Allowable Expenses under This Plan, in the absence of this COB provision; and
 - b. the benefits that would be payable for the Allowable Expenses under the Other Plan(s), in the absence of provisions with a purpose similar to that of this COB provision, whether or not a claim for benefits is made;exceeds Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the Other Plan(s) do not total more than Allowable Expenses.
2. When the benefits of This Plan are reduced as described above, each benefit is reduced proportionately and is then charged against any applicable benefit limit of This Plan.
3. The administrator will not, however, consider the benefits of the Other Plan(s) in determining benefits under This Plan when:
 - a. the Other Plan has a rule coordinating its benefits with those of This Plan and such rule states that benefits of the Other Plan will be determined after those of This Plan; and
 - b. the order of benefit determination rules requires Us to determine benefits before those of the Other Plan.

D. Right to Receive and Release Needed Information

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

E. Facility of Payment

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

F. Right of Recovery

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

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

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

G. Are You Also Covered by Medicare?

If You are also Covered by Medicare, We follow the Medicare Secondary Payor (MSP) rules to determine Your benefits. If Your Employer has 20 or fewer employees, the MSP rules might not apply. Please contact customer service at the toll free number on Your membership ID card if You have any questions.

GRIEVANCE PROCEDURE

A. INTRODUCTION

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

1. This Procedure is the exclusive method of resolving any Dispute. Exemplary or punitive damages are not available in any Grievance or litigation, pursuant to the terms of this EOC. Any decision to award damages must be based upon the terms of this EOC.
2. The Procedure can only resolve Disputes that are subject to Our control.
3. You cannot use this Procedure to resolve a claim that a Provider was negligent. Network Providers are independent contractors. They are solely responsible for making treatment decisions in consultation with their patients. You may contact the Plan, however, to complain about any matter related to the quality or availability of services, or any other aspect of Your relationship with Providers.
4. This Procedure incorporates the definitions of: (1) Adverse Benefit Determination; (2) urgent care; and (3) pre-service and post-service claims (“Claims”), that are in the Employee Retirement Income Security Act of 1974 (“ERISA”); Rules and Regulations for Administration and Enforcement; Claims Procedure (the “Claims Regulation”).

Adverse Benefit Determination means:

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

7. Any Dispute will be resolved in accordance with applicable Tennessee or Federal laws and regulations, the ASA and this EOC.

B. DESCRIPTION OF THE REVIEW PROCEDURES

1. Inquiry

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

2. First Level Grievance

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

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

a. Grievance Process

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

b. Written Decision

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

- (1) For a pre-service claim, within 30 days of receipt of Your request for review;
- (2) For a post-service claim, within 60 days of receipt of Your request for review; and
- (3) For a pre-service, urgent care claim, within 72 hours of receipt of Your request for review.

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

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

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

2. Second Level Grievance

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

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

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

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

a. Grievance Process

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

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

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

b. Written Decision

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

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

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

3. Independent Review of Medical Necessity Determinations

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

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

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

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

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

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

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

DEFINITIONS

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

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

In addition to the Coinsurance percentage, You are responsible for the difference between the Billed Charges and the Maximum Allowable Charge for Covered Services

if the Billed Charges of a Non-Contracted Provider or an Out-of-Network Provider are more than the Maximum Allowable Charge for such Services.

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

Complications of Pregnancy does not include false labor; occasional spotting; physician prescribed rest during the period of pregnancy; morning sickness; hyperemesis gravidarum and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.
15. **Concurrent Review** – The process of evaluating care during the period when Covered Services are being rendered.
16. **Copayment** – The dollar amount specified in Attachment C, Schedule of Benefits, that You are required to pay directly to a Provider for certain Covered Services. You must pay such Copayments at the time You receive those Services.
17. **Cosmetic Service** – Any surgical or non-surgical treatment, drugs or devices intended to alter or reshape the body for the purpose of improving appearance or self-esteem. Our Medical Policy establishes the criteria for what is cosmetic, and what is Medically Necessary and Appropriate.
18. **Covered Dependent** – A Subscriber's family member who: (1) meets the eligibility requirements of this EOC; (2) has been enrolled for Coverage; and (3) for whom the Plan has received the applicable Payment for Coverage.
19. **Covered Family Members** – A Subscriber and his or her Covered Dependents.
20. **Covered Services, Coverage or Covered** – Those Medically Necessary and Appropriate services and supplies that are set forth in Attachment A of this EOC, (that is incorporated by reference). Covered Services are subject to all the terms, conditions, exclusions and limitations of the Plan and this EOC.
21. **Custodial Care** – Any services or supplies provided to assist an individual in the activities of daily living as determined by the Plan including but not limited to eating, bathing, dressing or other self-care activities.
22. **Deductible** – The dollar amount, specified in Attachment C, Schedule of Benefits, that You must incur and pay for Covered Services during an Annual Benefit Period before the Plan provides benefits for services.

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

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

Provider, or the delegate actually billing for the Practitioner or Provider, and be within the scope of his or her licensure.

25. **Emergency** – A sudden and unexpected medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect to result in:
 - a. serious impairment of bodily functions; or
 - b. serious dysfunction of any bodily organ or part; or
 - c. placing a prudent layperson's health in serious jeopardy.Examples of Emergency conditions include: (1) severe chest pain; (2) uncontrollable bleeding; or (3) unconsciousness.
26. **Emergency Care Services** – Those services and supplies that are Medically Necessary and Appropriate in the treatment of an Emergency.
27. **Employee** – A person who fulfills all eligibility requirements established by the Employer and the administrator.
28. **Employer** – A corporation, partnership, union or other entity that is eligible for group coverage under State and Federal laws; and that enters into an Agreement with the administrator to provide Coverage to its Employees and their Eligible Dependents.
29. **ERISA** – The Employee Retirement Income Security Act of 1974, as amended.
30. **Hospital Confinement** – When You are treated as a registered bed patient at a Hospital or other Provider facility and incur a room and board charge.
31. **Hospital Services** – Covered Services that are Medically Appropriate to be provided by an Acute care Hospital.
32. **Incapacitated Child** – an unmarried child who is, and continues to be, both (1) incapable of self-sustaining employment by reason of intellectual disabilities (excluding mental illness) or physical handicap; and (2) chiefly dependent upon the Subscriber or Subscriber's spouse for economic support and maintenance.
 - a. If the child reaches this Plan's limiting age while Covered under this Plan, proof of such incapacity and dependency must be furnished within 31 days of when the child reaches the limiting age.
 - b. Incapacitated dependents of Subscribers of new groups, or of Subscribers who are newly eligible under this Plan, are eligible for Coverage if they were covered under the Subscriber's or the Subscriber's spouse's previous health benefit plan, and have less than a 63 day break in coverage from the prior plan. We may ask You to furnish proof of the incapacity and dependency upon enrollment.We may ask for proof that the child continues to meet the conditions of incapacity and dependency, but not more frequently than annually.
33. **Investigational** – The definition of "investigational" is based on the BlueCross and BlueShield of Tennessee's technology evaluation criteria. Any technology that fails to meet ALL of the following four criteria is considered to be investigational.
 - a. The technology must have final approval from the appropriate governmental regulatory bodies, as demonstrated by:

- (1) 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.
 - (2) Any approval that is granted as an interim step in the U.S. Food and Drug Administration's or any other federal governmental body's regulatory process is not sufficient.
- b. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes, as demonstrated by:
 - (1) The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.
 - (2) The evidence should demonstrate that the technology could measure or alter the physiological changes related to a disease, injury, illness, or condition. In addition, there should be evidence or a convincing argument based on established medical facts that such measurement or alteration affects health outcomes.
- c. The technology must improve the net health outcome, as demonstrated by:
 - (1) The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.
- d. The improvement must be attainable outside the investigational settings, as demonstrated by:
 - (1) In reviewing the criteria above, the medical policy panel will consider physician specialty society recommendations, the view of prudent medical practitioners practicing in relevant clinical areas and any other relevant factors.

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

- e. Your medical records, or
- f. the protocol(s) under which proposed service or supply is to be delivered, or
- g. any consent document that You have executed or will be asked to execute, in order to receive the proposed service or supply, or
- h. 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
- i. regulations or other official publications issued by the FDA and HHS, or
- j. 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

- k. the findings of the BlueCross BlueShield Association Technology Evaluation Center or other similar qualified evaluation entities.
- 34. **Late Enrollee** – An Employee or eligible Dependent who fails to apply for Coverage within: (1) 31 days after such person first became eligible for Coverage under this EOC; or (2) a subsequent Open Enrollment Period.
- 35. **Lifetime Maximum** – The maximum amount of benefits for Covered Services rendered to You during Your lifetime.
- 36. **Maintenance Care** - Medical services (including skilled services and therapies), prescription drugs, supplies and equipment for chronic, static or progressive medical conditions where the medical services: (1) fail to contribute toward cure; (2) fail to improve unassisted clinical function; (3) fail to significantly improve health; and (4) are indefinite or long-term in nature. This includes drugs used to treat chemical and methadone dependency maintenance.
- 37. **Maximum Allowable Charge** – The amount that the administrator, at its sole discretion, has determined to be the maximum amount payable for a Covered Service. That determination will be based upon the administrator's contract with a Network Provider or the amount payable based on the administrator's fee schedule for the Covered Services.
- 38. **Medicaid** – The program for medical assistance established under title XIX of the Social Security Act (42 U.S.C. 1396 et. seq.)
- 39. **Medical Director** – The physician designated by the administrator, or that physician's designee, who is responsible for the administration of the administrator's medical management programs, including its Authorization/Prior Authorization programs.
- 40. **Medically Appropriate** – Medically Appropriate – Services that have been determined by BlueCross, in its sole discretion, to be of value in the care of a specific Member. To be Medically Appropriate, a service must meet all of the following:
 - a. be Medically Necessary;
 - b. be consistent with generally accepted standards of medical practice for the Member's medical condition;
 - c. be provided in the most appropriate site and at the most appropriate level of service for the Member's medical condition;
 - d. not be provided solely to improve a Member's condition beyond normal variation in individual development, appearance and aging;
 - e. not be for the sole convenience of the Provider, Member or Member's family.
- 41. **Medically Necessary or Medical Necessity** – "Medically Necessary" means procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:
 - a. in accordance with generally accepted standards of medical practice; and
 - b. clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and

- c. not primarily for the convenience of the patient, physician or other health care provider; and
- d. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

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

- 42. **Medicare** – Title XVIII of the Social Security Act, as amended.
- 43. **Member, You, Your** – Any person enrolled as a Subscriber or Covered Dependent under the Plan.
- 44. **Member Payment** – The dollar amounts for Covered Services that You are responsible for as set forth in Attachment C, Schedule of Benefits, including Copayments, Deductibles, Coinsurance and Penalties. The administrator may require proof that You have made any required Member Payment.
- 45. **Network Benefit** – The Plan's payment level that applies to Covered Services received from a Network Provider. See Attachment C, Schedule of Benefits.
- 46. **Network Provider** – A Provider who has contracted with the administrator to provide access to benefits to Members at specified rates. Such Providers may be referred to as BlueCard PPO Participating Providers, Network hospitals, In-Transplant Network, etc.
- 47. **Non-Contracted Provider** – A Provider that renders Covered Services to a Member, in the situation where We have not contracted with that Provider type to provide those Covered Services. These Providers can change, as We contract with different Providers. A Provider's status as a Non-Contracted Provider, Network Provider, or Out-of-Network Provider can and does change. We reserve the right to change a Provider's status.
- 48. **Open Enrollment Period** – Those periods of time established by the Plan during which eligible Employees and their dependents may enroll as Members.
- 49. **Oral Appliance** – a device placed in the mouth and used to treat mild to moderate obstructive sleep apnea by repositioning or stabilizing the lower jaw, tongue, soft palate or uvula. An Oral Appliance may also be used to treat TMJ or TMD by stabilizing the jaw joint. An Oral Appliance is not the same as an occlusal splint, which is used to treat malocclusion or misalignment of teeth
- 50. **Out-of-Network Provider** – Any Provider who is an eligible Provider type but who does not hold a contract with the administrator to provide Covered Services.
- 51. **Out-of-Pocket Maximum** – The total dollar amount, as stated in Attachment C, Schedule of Benefits, that a Member must incur and pay for Covered Services during the Annual Benefit Period.
- 52. **Payment** – The total payment for Coverage under the Plan, including amounts paid by You and the Employer for such Coverage.

53. **Payor(s)** – An insurer, health maintenance organization, no-fault liability insurer, self-insurer or other entity that provides or pays for a Member's health care benefits.
54. **Penalty/Penalties** – Additional Member payments required as a result of failure to comply with Plan requirements such as failing to obtain Prior Authorization for certain Covered Services shown in Attachment C, Schedule of Benefits, as requiring such Prior Authorization. The Penalty will be a reduction in the Plan payment for Covered Services.
55. **Periodic Health Screening** – An assessment of patient's health status at intervals set forth in the administrator's Medical Policy for the purpose of maintaining health and detecting disease in its early state. This assessment should include:
 - a. a complete history or interval update of the patient's history and a review of systems; and
 - b. a physical examination of all major organ systems, and screening tests per the administrator's Medical Policy.
56. **Practitioner** – A person licensed by the State to provide medical services.
57. **Prescription Drug** – A medication containing at least one Legend Drug that may not be dispensed under applicable state or federal law without a Prescription, and/or insulin.
58. **Prior Authorization, Authorization** – A review conducted by the administrator, prior to the delivery of certain services, to determine if such services will be considered Covered Services.
59. **Provider** – A person or entity engaged in the delivery of health services who or that is licensed, certified or practicing in accordance with applicable State or Federal laws.
60. **Qualified Medical Child Support Order** – A medical child support order, issued by a court of competent jurisdiction or state administrative agency that creates or recognizes the existence of a child's right to receive benefits for which a Subscriber is eligible under the Plan. Such order shall identify the Subscriber and each such child by name and last known mailing address; give a description of the type and duration of coverage to be provided to each child; and identify each health plan to which such order applies.
61. **Specialty Drugs** – Injectable, infusion and select oral medications that require complex care, including special handling, patient education and continuous monitoring. Specialty Drugs are listed on the administrator's Specialty Drugs list. Specialty Drugs are categorized as provider-administered or self-administered..
62. **Subscriber** – An Employee who meets all applicable eligibility requirements, has enrolled for Coverage and who has submitted the applicable Payment for Coverage.
63. **Surgery or Surgical Procedure** - Medically Necessary and Appropriate surgeries or procedures. Surgeries involve an excision or incision of the body's skin or mucosal tissues, treatment of broken or dislocated bones, and/or insertion of instruments for exploratory or diagnostic purposes into a natural body opening.
64. **Totally Disabled or Total Disability** – Either:
 - a. An Employee who is prevented from performing his or her work duties and is unable to engage in any work or other gainful activity for which he or she is

qualified or could reasonably become qualified to perform by reason of education, training, or experience because of injury or disease; or

- b. A Covered Dependent who is prevented from engaging in substantially all of the normal activities of a person of like age and sex in good health because of non-occupational injury or disease.
- 65. **Transplant Maximum Allowable Charge (TMAC)** – The amount that the administrator, in its sole discretion, has determined to be the maximum amount payable for covered Services for Organ Transplants. Each type of Organ Transplant has a separate TMAC.
 - 66. **Transplant Network** – A network of hospitals and facilities, each of which has agreed to perform specific organ transplants. For example, some hospitals might contract to perform heart transplants, but not liver transplants.
 - 67. **Transplant Network Institution** – A facility or hospital that has contracted with the administrator (or with an entity on behalf of the administrator) to provide Transplant Services for some or all organ and bone marrow transplant procedures Covered under this EOC. For example, some hospitals might contract to perform heart transplants, but not liver transplants. An In-Transplant Network Institution is a Network Provider when performing contracted transplant procedures in accordance with the requirements of this EOC.
 - 68. **Transplant Services** – Medically Necessary and Appropriate Services listed as Covered under the Transplant Services section in Attachment A of this EOC.
 - 69. **Waiting Period** – The time that must pass before an Employee or Dependent is eligible to be Covered for benefits under the Plan.
 - 70. **Well Child Care** – A routine visit to a pediatrician or other qualified Practitioner to include Medically Necessary and Medically Appropriate Periodic Health Screenings, immunizations and injections for children through age 5.
 - 71. **Well Woman Exam** – A routine visit every 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
EVIDENCE OF COVERAGE**

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

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

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

Please also read Attachment B: Other Exclusions.

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

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

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

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

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

A Clinical Trial is a prospective biomedical or behavioral research study of human subjects that is designed to answer specific questions about biomedical or behavioral interventions (vaccines, drugs, treatments, devices, or new ways of using known drugs, treatments, or devices). Clinical Trials are used to determine whether new biomedical or behavioral interventions are safe, efficacious, and effective. Routine patient care associated with an approved Clinical Trial will be Covered under the Plan's benefits in accordance with the Plan's medical policies and procedures.

A. Preventive Health Care Services

Medically Necessary and Appropriate Preventive Health Care Services.

1. Covered Services

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

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

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

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

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

2. Exclusions

- a. Office visits, physical exams and related immunizations and tests when required solely for: (1) sports; (2) camp; (3) employment; (4) travel; (5) insurance; (6) marriage or legal proceedings.

B. Practitioner Office Services

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

1. Covered Services

- a. Diagnosis and treatment of illness or injury. (Note that allergy skin testing is Covered only in the practitioner office setting. Medically Necessary RAST (radioallergosorbent test), FAST (fluorescent allergosorbent test), or MAST (multiple radioallergosorbent test) allergy testing is Covered in the practitioner office setting and in a licensed laboratory.)
- b. Injections and medications administered in a Practitioner's office, except Specialty Drugs. (See Provider Administered Specialty Drugs section for information on Coverage).
- c. Second surgical opinions given by a Practitioner who is not in the same medical group as the Practitioner who initially recommended the Surgery.

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. Rehabilitative therapies in excess of the limitations of the Therapeutic/ Rehabilitative benefit.
- c. Dental procedures, except as otherwise indicated in this EOC.

C. Inpatient Hospital Services

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

1. Covered Services

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

2. Exclusions

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

D. Hospital Emergency Care Services

Medically Necessary and Appropriate health care services and supplies furnished in a hospital emergency department that are required to determine, evaluate and/or treat an Emergency

Medical Condition until such condition is stabilized, as directed or ordered by the Practitioner or hospital protocol.

1. Covered Services

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

2. Exclusions

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

E. Ambulance Services

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

1. Covered Services

- a. Medically Necessary and Appropriate land or air transportation from the scene of an accident or Emergency to the nearest appropriate hospital.

2. Exclusions

- a. Transportation for Your convenience.
- b. Transportation that is not essential to reduce the probability of harm to the patient.
- c. Services when You are not transported to a hospital.

F. Outpatient Facility Services

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

1. Covered Services

- a. Practitioner services.
- b. Outpatient diagnostics (such as x-rays and laboratory services).
- c. Outpatient treatments (such as medications and injections.)
- d. Outpatient Surgery and supplies.
- e. Observation stays less than 24 hours.

2. Exclusions

- a. Rehabilitative therapies in excess of the terms of the Therapeutic/ Rehabilitative benefit.
- b. Services that could be provided in a less intensive setting.

G. Family Planning and Reproductive Services

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

1. Covered Services

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

2. Exclusions

- a. Services or supplies that are designed to create a pregnancy, enhance fertility or improve conception quality, including but not limited to: (1) artificial insemination; (2) in vitro fertilization; (3) fallopian tube reconstruction; (4) uterine reconstruction; (5) assisted reproductive technology (ART) including but not limited to GIFT and ZIFT; (6) fertility injections; (7) fertility drugs, (8) services for follow-up care related to infertility treatments.
- b. Services or supplies for the reversals of sterilizations.
- c. Induced abortion unless: (1) the health care Practitioner certifies in writing that the pregnancy would endanger the life of the mother; or (2) the fetus is not viable; or (3) the pregnancy is a result of rape or incest; or (4) the fetus has been diagnosed with a lethal or otherwise significant abnormality.

H. Reconstructive Surgery

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

1. Covered Services

- a. Surgery to correct significant defects from congenital causes (except where specifically excluded), accidents or disfigurement from a disease state.
- b. Reconstructive breast Surgery as a result of a mastectomy (other than lumpectomy) including Surgery on the non-diseased breast needed to establish symmetry between the two breasts.

2. Exclusions

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

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

I. Skilled Nursing/Rehabilitative Facility Services

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

1. Covered Services
 - a. Room and board in a semi-private room; general nursing care; medications, diagnostics and special care units.
 - b. The attending Practitioner's services for professional care.
 - c. Coverage is limited as indicated in Attachment C: Schedule of Benefits.
2. Exclusions
 - a. Custodial, domiciliary or private duty nursing services.
 - b. Skilled Nursing services not received in a Medicare certified skilled nursing facility.

J. Therapeutic/Rehabilitative Services

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

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

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

Speech therapy is Covered only for disorders of articulation and swallowing, resulting from Acute illness, injury, stroke, autism in children under age 12, or cleft palate.
 - b. Coverage is limited as indicated in Attachment C: Schedule of Benefits.
 - c. The limit on the number of visits for therapy applies to all visits for that therapy, whether received in a Practitioner's office, outpatient facility or home health setting.
 - d. Services received during an inpatient hospital, skilled nursing or rehabilitative facility stay are Covered as shown in the inpatient hospital, skilled nursing or rehabilitative facility section, and are not subject to the therapy visit limits.
2. Exclusions

- a. Treatment beyond what can reasonably be expected to significantly improve health, including therapeutic treatments for ongoing maintenance or palliative care.
- b. Enhancement therapy that is designed to improve Your physical status beyond Your pre-injury or pre-illness state.
- c. Complementary and alternative therapeutic services, including, but not limited to: (1) massage therapy; (2) acupuncture; (3) craniosacral therapy; (4) vision exercise therapy; and (5) neuromuscular reeducation. Neuromuscular reeducation refers to any form of athletic training, rehabilitation program or bodily movement that requires muscles and nerves to learn or relearn a certain behavior or specific sequence of movements. Neuromuscular reeducation is sometimes performed as part of a physical therapy visit.
- d. Modalities that do not require the attendance or supervision of a licensed therapist. These include, but are not limited to: (1) activities that are primarily social or recreational in nature; (2) simple exercise programs; (3) hot and cold packs applied in the absence of associated therapy modalities; (4) repetitive exercises or tasks that You can perform without a therapist, in a home setting; (5) routine dressing changes; and (6) custodial services that can ordinarily be taught to You or a caregiver.
- e. Behavioral therapy, play therapy, communication therapy, and therapy for self correcting language dysfunctions as part of speech therapy, physical therapy or occupational therapy programs. Behavioral therapy and play therapy for behavioral health diagnoses may be Covered under the Behavioral Health section (if applicable to Your Group Coverage).
- f. Duplicate therapy. For example, when You receive both occupational and speech therapy, the therapies should provide different treatments and not duplicate the same treatment.

K. Organ Transplants

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

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

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

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

1. Prior Authorization Procedures

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

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

2. Covered Services

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

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

3. Conditions/Limitations

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

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

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

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

4. Exclusions

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

- a. Transplants and related services that did not receive Prior Authorization;
- b. Any service specifically excluded under Attachment B: Other Exclusions, except as otherwise provided in this section;
- c. Services or supplies not specified as Covered Services under this section;
- d. Any attempted Covered Procedure that was not performed, except where such failure is beyond Your control;
- e. Non-Covered Services;
- f. Services that are covered under any private or public research fund, regardless of whether You applied for or received amounts from such fund;
- g. Any non-human, artificial or mechanical organ;
- h. Payment to an organ donor or the donor's family as compensation for an organ, or payment required to obtain written consent to donate an organ;
- i. Donor services including screening and assessment procedures that have not received Prior Authorization from Us;
- j. Removal of an organ from a Member for purposes of transplantation into another person, except as Covered by the Donor Organ Procurement provision as described above;

- k. Harvest, procurement, and storage of stem cells, whether obtained from peripheral blood, cord blood, or bone marrow when reinfusion is not scheduled or anticipated to be scheduled within an appropriate time frame for the patient's covered stem cell transplant diagnosis;
- l. Other non-organ transplants (e.g., cornea) are not Covered under this Section, but may be Covered as an inpatient Hospital Service or outpatient facility service, if Medically Necessary.

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

L. Dental Services

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

1. Covered Services

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

Prior Authorization for inpatient services is required.

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

2. Exclusions

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

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

- b. Treatment for correction of underbite, overbite, and misalignment of the teeth, including, but not limited to, braces for dental indications, orthognathic surgery, and occlusal splints and occlusal appliances to treat malocclusion/misalignment of teeth.
- c. Extraction of impacted teeth, including wisdom teeth.

M. Temporomandibular Joint Dysfunction (TMJ)

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

1. Covered Services

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

2. Exclusions

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

N. Diagnostic Services

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

1. Covered Services

- a. Imaging services ordered by a Practitioner, including x-ray, ultrasound, bone density test, and Advanced Radiological Imaging Services. Advanced Radiological Imaging Services include MRIs, CT scans, PET scans, nuclear cardiac imaging.
- b. Diagnostic laboratory services ordered by a Practitioner.

2. Exclusions

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

O. Durable Medical Equipment

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

1. Covered Services

- a. Rental of Durable Medical Equipment - Maximum allowable rental charge not to exceed the total Maximum Allowable Charge for purchase. If You rent the same type of equipment from multiple DME Providers, and the total rental charges from the multiple Providers exceed the purchase price of a single piece of equipment, You will be responsible for amounts in excess of the Maximum Allowable Charge for purchase.
- b. The repair, adjustment or replacement of components and accessories necessary for the effective functioning of Covered Durable Medical Equipment.
- c. Supplies and accessories necessary for the effective functioning of Covered Durable Medical Equipment.
- d. The replacement of items needed as the result of normal wear and tear, defects, obsolescence or aging. Insulin pump replacement is Covered only for pumps older than 48 months and only if the pump cannot be repaired.

2. Exclusions

- a. Charges exceeding the total cost of the Maximum Allowable Charge to purchase the Durable Medical Equipment.
- b. Unnecessary repair, adjustment or replacement or duplicates of any such Durable Medical Equipment.
- c. Supplies and accessories that are not necessary for the effective functioning of the Covered equipment.
- d. Items to replace those that were lost, damaged, stolen or prescribed as a result of new technology.
- e. Items that require or are dependent on alteration of home, workplace or transportation vehicle.
- f. Motorized scooters, exercise equipment, hot tubs, pools, saunas.
- g. "Deluxe" or "enhanced" equipment. The most basic equipment that will provide the needed medical care will determine the benefit.
- h. Computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, and seat lifts of any kind,
- i. Patient lifts, auto tilt chairs, air fluidized beds, or air flotation beds, unless approved by Case Management for a Member who is in Case Management.
- j. Portable ramp for a wheelchair.

P. Prosthetics/Orthotics

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

1. Covered Services

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

2. Exclusions

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

Q. Diabetes Treatment

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

1. Covered Services

- a. Blood glucose monitors, including monitors designed for the legally blind.
- b. Test strips for blood glucose monitors.
- c. Visual reading and urine test strips.
- d. Insulin.
- e. Injection aids.

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

R. Supplies

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

1. Covered Services
- a. Supplies for the treatment of disease or injury used in a Practitioner's office, outpatient facility, or inpatient facility.
 - b. Supplies for treatment of disease or injury that are prescribed by a Practitioner and cannot be obtained without a Practitioner's prescription.
2. Exclusions
- a. Supplies that can be obtained without a prescription, except for diabetic supplies. Examples include but are not limited to: (1) adhesive bandages; (2) dressing material for home use; (3) antiseptics, (4) medicated creams and ointments; (5) cotton swabs; and (6) eyewash.

S. Home Health Care Services

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

1. Covered Services
- a. Part-time, intermittent health services, supplies and medications, by or under the supervision of a registered nurse.
 - b. Home infusion therapy.
 - c. Rehabilitative therapies such as physical therapy, occupational therapy, etc. (subject to the limitations of the Therapeutic/Rehabilitative benefit).

- d. Medical social services.
- e. Dietary guidance.
- f. Coverage is limited as indicated in Attachment C: Schedule of Benefits.

2. Exclusions

- a. Items such as non-treatment services or: (1) routine transportation; (2) homemaker or housekeeping services; (3) behavioral counseling; (4) supportive environmental equipment; (5) Maintenance Care or Custodial Care; (6) social casework; (7) meal delivery; (8) personal hygiene; and (9) convenience items.
- b. Services that were not Authorized by the Plan.

T. Hospice

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

1. Covered Services

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

2. Exclusions

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

U. Behavioral Health Services

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

1. Covered Services

- a. Inpatient and outpatient services for care and treatment of mental health disorders and substance abuse disorders.

2. Exclusions

- a. Pastoral counseling.
- b. Marriage and family counseling without a behavioral health diagnosis.
- c. Vocational and educational training and/or services.
- d. Custodial or domiciliary care.
- e. Conditions without recognizable ICD-9 diagnostic classification, such as adult child of alcoholics (ACOA), and co-dependency and self-help programs.
- f. Sleep disorders.
- g. Services related to mental retardation.

- h. Habilitative as opposed to rehabilitative services, i.e., services to achieve a level of functioning the individual has never attained.
- i. Court ordered examinations and treatment, unless Medically Necessary.
- j. Pain management.
- k. Hypnosis or regressive hypnotic techniques.
- l. Charges for telephone consultations, missed appointments, completion of forms, or other administrative services

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

V. Vision

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

1. Covered Services

- a. Services and supplies for the diagnosis and treatment of diseases and injuries to the eye.
- b. First set of eyeglasses or contact lens required to adjust for vision changes due to cataract surgery and obtained within 6 months following the surgery.
- c. One routine vision exam, including refraction, to detect vision impairment every other calendar year.

2. Exclusions

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

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

W. Prescription Drugs

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

1. Covered Services

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

2. Exclusions

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

ATTACHMENT B: OTHER EXCLUSIONS

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

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

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

34. Private duty nursing.
35. Services or supplies to treat sexual dysfunction, regardless of cause, including but not limited to erectile dysfunction (e.g. Viagra), delayed ejaculation, anorgasmia and decreased libido.
36. Services or supplies related to complications of cosmetic procedures, complications of bariatric Surgery; re-operation of bariatric Surgery or body remodeling after weight loss.
37. Cranial orthosis, including helmet or headband, for the treatment of non-synostotic plagiocephaly.
38. Chelation therapy, except for (1) control of ventricular arrhythmias or heart block associated with digitalis toxicity; (2) Emergency treatment of hypercalcemia; (3) extreme conditions of metal toxicity, including thalassemia with hemosiderosis; (4) Wilson's disease (hepatolenticular degeneration); and (5) lead poisoning;
39. Vagus nerve stimulation for the treatment of depression;
40. Balloon sinuplasty for treatment of chronic sinusitis;
41. Treatment for benign gynecomastia;
42. Treatment for hyperhidrosis;
43. Intradiscal annuloplasty to treat discogenic back pain. This procedure provides controlled delivery of heat to the intervertebral disc through an electrode or coil.
44. Methadone and methadone maintenance therapy.

ATTACHMENT C: CDHP SCHEDULE OF BENEFITS

Group Name: West Fraser, Inc.

Group Number: 125225

Annual Benefit Plan: 1/1/2015

Network: S

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

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

	Network Services received from Network Providers	Out-of-Network Services received from Out-of-Network Providers
Maximum	Unlimited	
Deductible ¹		
Individual	\$1,500	\$1,500
Family	\$3,000	\$3,000
Out-of-Pocket Maximum ²		
Individual	\$3,000	\$3,000
Family	\$6,000	\$6,000

1. DEDUCTIBLE

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

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

Dollar amounts incurred during the last 3 months of a Calendar Year that are applied to the Deductible during that Calendar Year will not apply to the Deductible for the next Calendar Year.

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

2. OUT-OF-POCKET

There are 2 Out-of-Pocket Maximums – one for services rendered by Network Providers and one for services rendered by Out-of-Network Providers.

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

When the Out-of-Pocket Maximum, Network Providers, is satisfied, 100% of available benefits is payable for other Covered Services from Network Providers incurred by the Member during the

remainder of that Calendar Year, excluding applicable Penalties, and any balance of charges (the difference between Billed Charges and the Maximum Allowable Charge).

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

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Preventive Health Care Services		
Well Child Care	100%	60 % of the Maximum Allowable Charge
Well Woman Exam	100%	60 % of the Maximum Allowable Charge
Mammogram, Cervical cancer Screening and Prostate cancer Screening	100%	60 % of the Maximum Allowable Charge
Immunizations	100%	60 % of the Maximum Allowable Charge
Preventive/Well Care Services Includes preventive health exam, screenings and counseling services. Alcohol misuse and tobacco use counseling limited to 8 visits annually; must be provided in the primary care setting; Dietary counseling for adults with hyperlipidemia, hypertension, Type 2 diabetes, coronary artery disease and congestive heart failure limited to 6 visits annually.	100%	60 % of the Maximum Allowable Charge
Other Well Care Screenings, age 6 and above including flexible sigmoidoscopy or colonoscopy	100%	60 % of the Maximum Allowable Charge
Lactation counseling by a trained provider during pregnancy or in the post-partum period. Limited to one visit per pregnancy.	100%	60 % of the Maximum Allowable Charge
Manual Breast Pump, limited to one per pregnancy	100%	60 % of the Maximum Allowable Charge
FDA-approved contraceptive methods, sterilization procedures and counseling for women with reproductive capacity.	100%	60 % of the Maximum Allowable Charge

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Services Received at the Practitioner's Office		
Office Exams and Consultations		
Diagnosis and treatment of illness or injury Primary Care Practitioner types (Internal Medicine, General Practice, Family Medicine, Pediatrics, Obstetrics & Gynecology) All other Practitioners The Copayment for a Physician Assistant or Nurse Practitioner may be based on the Provider type of the delegate physician.	85 % after Deductible	60 % of the Maximum Allowable Charge after Deductible
Maternity care The Copayment applies to the initial office visit to confirm pregnancy. For benefits for subsequent prenatal visits, postnatal visits and the physician delivery charge, see Inpatient Hospital Stays, including maternity stays in the section Services Received at a Facility. Benefits for specialty care, even if related to pregnancy, are considered as any other illness, and a separate Copayment will apply.	85 % after Deductible	60 % of the Maximum Allowable Charge after Deductible
Injections and Immunizations		
Allergy injections and allergy extract	85 %	60 % of the Maximum Allowable Charge
Provider-administered Specialty Drugs	85 % after Deductible	60 % of the Maximum Allowable Charge after Deductible
All other medicine injections, excluding Specialty Drugs. For surgery injections, please see Office Surgery under the Other office procedures, services or supplies section.	85 %	60 % of the Maximum Allowable Charge
Diagnostic Services and Preventive Screenings (e.g. x-ray and labwork)		
Allergy Testing	85 % after Deductible	60 % of the Maximum Allowable Charge after Deductible

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Services Received at the Practitioner's Office		
Advanced Radiological Imaging Includes CAT scans, CT scans, MRIs, PET scans, nuclear medicine and other similar technologies. Advanced Radiological Imaging services require Prior Authorization. If Prior Authorization is not obtained, benefits may be reduced by \$500 for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). (See the Prior Authorization section for more information.) Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization.	85 % after Deductible	60 % of the Maximum Allowable Charge after Deductible
All Other Diagnostic Services for illness or injury	85 % after Deductible	60 % of the Maximum Allowable Charge after Deductible
Maternity care diagnostic services	85 % after Deductible	60 % of the Maximum Allowable Charge after Deductible

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Services Received at the Practitioner's Office		
Other office procedures, services or supplies		
Office Surgery, including anesthesia, performed in and billed by the Practitioner's office Primary Care Practitioner types All other Practitioners The Copayment for a Physician Assistant or Nurse Practitioner may be based on the Provider type of the delegate physician. Some procedures require Prior Authorization. Call Our consumer advisors to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, benefits may be reduced by \$500 for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). (See the Prior Authorization section for more information.) Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization. Surgeries include incisions, excisions, biopsies, injection treatments, fracture treatments, applications of casts and splints, sutures, and invasive diagnostic services (e.g., colonoscopy, sigmoidoscopy and endoscopy).	85 % after Deductible	60 % of the Maximum Allowable Charge after Deductible
Non-routine treatments: Includes renal dialysis, radiation therapy, chemotherapy and infusions. Does not apply to Specialty Drugs. See Provider-Administered Specialty Drugs section for applicable benefit.	85 % after Deductible	60 % of the Maximum Allowable Charge after Deductible
All Other Office services	85 % after Deductible	60 % of the Maximum Allowable Charge after Deductible

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Services Received at a Facility		
Inpatient Hospital Stays, including maternity stays: Prior Authorization required. Benefits may be reduced by \$500 for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers) when Prior Authorization is not obtained. (See the Prior Authorization section for more information.) Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization.		
Facility charges	85 % after Deductible	60 % of the Maximum Allowable Charge after Deductible
Inpatient Hospice care	85 % after Deductible	60 % of the Maximum Allowable Charge after Deductible
Practitioner charges (including global maternity delivery charges billed as inpatient service)	85 % after Deductible	60 % of the Maximum Allowable Charge after Deductible
Skilled Nursing or Rehab Facility stays (Limited to 120 days per Annual Benefit Period) Prior Authorization required for Out-of-Network Providers. Benefits may be reduced by \$500 for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers) when Prior Authorization is not obtained. (See the Prior Authorization section for more information.) Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization.		
Facility charges	85 % after Deductible	60 % of the Maximum Allowable Charge after Deductible
Practitioner charges	85 % after Deductible	60 % of the Maximum Allowable Charge after Deductible
Hospital Emergency Care Services		
Emergency Room charges	85 % after Deductible	85 % after Deductible
Advanced Radiological Imaging Services Includes CAT scans, CT scans, MRIs, PET scans, nuclear medicine and other similar technologies.	85 % after Deductible	85 % after Deductible
All Other Hospital Charges	85 % after Deductible	85 % after Deductible
Practitioner Charges	85 % after Deductible	85 % after Deductible

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Services Received at a Facility		
Outpatient Facility Services Outpatient Surgery Some procedures require Prior Authorization. Call Our consumer advisors to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, benefits may be reduced by \$500 for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). (See the Prior Authorization section for more information.) Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization. Surgeries include invasive diagnostic services (e.g., colonoscopy, sigmoidoscopy).		
Facility charges	85 % after Deductible	60 % of the Maximum Allowable Charge after Deductible
Practitioner charges	85 % after Deductible	60 % of the Maximum Allowable Charge after Deductible
Outpatient Diagnostic Services and Outpatient Screenings		
Advanced Radiological Imaging Includes CAT scans, CT scans, MRIs, PET scans, nuclear medicine and other similar technologies. Advanced Radiological Imaging services require Prior Authorization. If Prior Authorization is not obtained, benefits may be reduced by \$500 for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers). (See the Prior Authorization section for more information.) Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization.	85 % after Deductible	60 % of the Maximum Allowable Charge after Deductible
All other Diagnostic Services for illness or injury	85 % after Deductible	60 % of the Maximum Allowable Charge after Deductible
Maternity care diagnostic services	85 % after Deductible	60 % of the Maximum Allowable Charge after Deductible

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Services Received at a Facility		
Other Outpatient Services		
Non-routine treatments: Includes renal dialysis, radiation therapy, chemotherapy and infusions. Does not apply to Specialty Drugs. See Provider Administered Specialty Drugs section for applicable benefit.	85 % after Deductible	60 % of the Maximum Allowable Charge after Deductible
Provider Administered Specialty Drugs	85 % after Deductible	60 % of the Maximum Allowable Charge after Deductible
All Other services received at an outpatient facility, including chemotherapy, radiation therapy, injections, infusions, and renal dialysis	85 % after Deductible	60 % of the Maximum Allowable Charge after Deductible
Urgent Care	85 % after Deductible	60 % of the Maximum Allowable Charge after Deductible

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Other Services		
Ambulance	85 % after Deductible	85 % after Deductible
Home Health Care Services, including home infusion therapy Prior Authorization is required for skilled nurse visits in the home. Physical, speech or occupational therapy provided in the home do not require Prior Authorization. Limited to 40 visits per Annual Benefit Period	85 % after Deductible	60 % of the Maximum Allowable Charge after Deductible
Outpatient Hospice Care, limited to 360 days per lifetime	85 % after Deductible	60 % of the Maximum Allowable Charge after Deductible
Therapy Services: Physical, speech, occupational, cardiac and pulmonary rehab therapy, unlimited visits	85 % after Deductible	60 % of the Maximum Allowable Charge after Deductible
Manipulative therapy, limited to 30 visits per Annual benefit period	85 % after Deductible	60 % of the Maximum Allowable Charge after Deductible
DME, Orthotics and Prosthetics	85 % after Deductible	60 % of the Maximum Allowable Charge after Deductible
Supplies	85 % after Deductible	60 % of the Maximum Allowable Charge after Deductible
Prescription Drugs	85 % after Deductible	60 % of the Maximum Allowable Charge after Deductible
Dental-Accidental	85 % after Deductible	85 % of the Maximum Allowable Charge after Deductible

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Other Services – Hearing Aids		
Hearing Aids Limited to one per ear every 3 years (as determined by Your Annual Benefit Period).	85 % after Deductible	85 % of the Maximum Allowable Charge after Deductible

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Organ Transplant Services		
Organ Transplant Services, all transplants except kidney All Organ Transplants require Prior Authorization. Benefits will be denied without Prior Authorization. Transplant Network Providers are different from Network Providers for other services. Call customer service before any pre-transplant evaluation or other Transplant Service is performed to request Authorization, and to obtain information about Transplant Network Providers. Network Providers that are not in the Transplant Network may balance bill the Member for amounts over TMAC not Covered by the Plan.	In-Transplant Network benefits: 85 % after Network Deductible, Network Out-of-Pocket Maximum applies.	Network Providers not in Our Transplant Network (Network Providers not in our Transplant Network include Network Providers in Tennessee and BlueCard PPO Providers outside Tennessee): 85 % of Transplant Maximum Allowable Charge (TMAC) after Network Deductible, Network Out-of-Pocket Maximum applies, amounts over TMAC do not apply to the Out-of-Pocket Maximum and are not Covered.
Organ Transplant Services, kidney transplants All Organ Transplants require Prior Authorization. Benefits will be denied without Prior Authorization. Call customer service before any pre-transplant evaluation or other Transplant Service is performed to request Authorization.	85 % after Network Deductible; Network Out-of-Pocket Maximum applies.	Out-of-Network Providers: 60 % of Transplant Maximum Allowable Charge (TMAC), after Out-of-Network Deductible, Out-of-Network Out-of-Pocket Maximum applies, amounts over TMAC do not apply to the Out-of-Pocket and are not Covered.

ATTACHMENT D: STATEMENT OF ERISA RIGHTS

For the purposes of this Attachment D, the term “Plan” means the employee welfare benefit plan sponsored by the Plan Sponsor (usually, the 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 the Employer) and at other specified locations, such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration;
2. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator (Plan Sponsor, i.e., the Employer). The Plan Administrator may make a reasonable charge for these copies; and
3. Receive a summary of the plan’s annual financial report. The Plan Administrator (Plan Sponsor, usually the Employer) is required by law to furnish each participant with a copy of this summary annual report.
4. Obtain a statement telling You whether You have a right to receive a pension at normal retirement age and if so, what Your benefits would be at normal retirement age if You stop working under the Plan now. If You do not have a right to a pension, the statement will tell You how many more years You have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The Plan must provide the statement free of charge.
5. Continue Your health care Coverage if there is a loss of coverage under the Plan as a result of a qualifying event. You may have to pay for such Coverage. Review the Continuation of Coverage section of this EOC for the rules governing Your COBRA Continuation Coverage rights.

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

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

concerning the qualified status of a domestic relations order or a Medical Child Support Order, You may file suit in federal court. If plan fiduciaries misuse the Plan's money or if You are discriminated against for asserting Your rights, You may seek assistance from the U. S. Department of Labor, or may file suit in a federal court.

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

If You have any questions about Your plan, You should contact the Plan Administrator (Plan Sponsor, i.e., the 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 Administrator, 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.

GENERAL LEGAL PROVISIONS

INDEPENDENT LICENSEE OF THE BLUECROSS BLUESHIELD ASSOCIATION

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

RELATIONSHIP WITH NETWORK PROVIDERS

A. Independent Contractors

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

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

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

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

B. Termination of Providers’ Participation

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

C. Provider Directory

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

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

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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

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

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

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

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

SUBROGATION AND RIGHT OF REIMBURSEMENT

A. Subrogation Rights

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

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

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

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

B. Priority Right of Reimbursement

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

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

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

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

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

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

Notice and Cooperation

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

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

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

Legal Action and Costs

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

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

Settlement or Other Compromise

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

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

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

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

NOTICE OF PRIVACY PRACTICES

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

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

LEGAL OBLIGATIONS

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

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

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

ORGANIZATIONS COVERED BY THIS NOTICE

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

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

USES AND DISCLOSURES OF YOUR INFORMATION

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

1. **TREATMENT:** Your health plan information may be disclosed to a healthcare provider that asks for it to provide treatment.
2. **PAYMENT:** Your health plan information may be used or disclosed to pay claims for services or to coordinate benefits that are covered under Your health insurance policy.
3. **HEALTH CARE OPERATIONS:** Your health plan information may be used and disclosed to determine premiums, conduct quality assessment and improvement

activities, to engage in care coordination or case management, accreditation, conducting and arranging legal services, fraud prevention and investigation, wellness, disease management, and for other similar administrative purposes.

4. **AUTHORIZATIONS:** You may provide written authorization to use Your health plan information or to disclose it to anyone for any purpose. You may revoke Your authorization in writing at any time. That revocation will not affect any use or disclosure permitted by Your authorization while it was in effect. Employer cannot use or disclose Your health plan information except as described in this notice, without Your written authorization. Examples of where an authorization would be required include: most uses and disclosures of psychotherapy notes (if recorded by a covered entity), uses and disclosures for marketing purposes, disclosures that constitute a sale of PHI, other uses and disclosures not described in this notice.
5. **PERSONAL REPRESENTATIVE:** Your health plan information may be disclosed to a family member, friend or other person as necessary to help with Your health care or with payment for Your health care. You must agree that the Employer may do so, as described in the Individual Rights section of this notice.
6. **PLAN SPONSORS:** Your health plan information, and the health plan information of others enrolled in Your group health plan, may be disclosed to Your plan sponsor in order to perform plan administration functions. Please see Your plan documents for a full description of the uses and disclosures the plan sponsor may make of Your health plan information in such circumstances.
7. **UNDERWRITING:** Your health plan information may be received for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a health insurance or benefits contract. If the Employer does not issue that contract, Your health plan information will not be used or further disclosed for any other purpose, except as required by law. Additionally, health plans are prohibited from using or disclosing genetic information of an individual for underwriting purposes pursuant to the Genetic Information Nondiscrimination Act of 2008 (GINA).
8. **MARKETING:** Your health plan information may be used to provide information about health-related benefits, services or treatment alternatives that may be of interest to You. Your health plan information may be disclosed to a business associate assisting us in providing that information to You. We will not market products or services other than health-related products or services to You unless You affirmatively opt-in to receive information about non-health products or services We may be offering. You have the right to opt out of fundraising communications.
9. **RESEARCH:** Your health plan information may be used or disclosed for research purposes, as allowed by law.
10. **YOUR DEATH:** If You die, Your health plan information may be disclosed to a coroner, medical examiner, funeral director or organ procurement organization.
11. **AS REQUIRED BY LAW:** Your health plan information may be used or disclosed as required by state or federal law.
12. **COURT OR ADMINISTRATIVE ORDER:** Health plan information may be disclosed in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances.
13. **VICTIM OF ABUSE:** If You are reasonably believed to be a victim of abuse, neglect, domestic violence or other crimes, health plan information may be released to the

extent necessary to avert a serious threat to Your health or safety or to the health or safety of others. Health plan information may be disclosed, when necessary, to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

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

INDIVIDUAL RIGHTS

1. **DESIGNATED RECORD SET:** You have the right to look at or get copies of Your health plan information, with limited exceptions. You must make a written request, using a form available from the Privacy Office, to obtain access to Your health plan information. If You request copies of Your health plan information, You will be charged 25¢ per page, \$10 per hour for staff time required to copy that information, and postage if You want the copies mailed to You. If You request an alternative format, the charge will be based upon the cost of providing Your health plan information in the requested format. If You prefer, the Employer will prepare a summary or explanation of Your health plan information for a fee. For a more detailed explanation of the fee structure, please contact the Privacy Office. Employer requires advance payment before copying Your health plan information.
2. **ACCOUNTING OF DISCLOSURES:** You have the right to receive an accounting of any disclosures of Your health plan information made by the Employer or a business associate for any reason, other than treatment, payment, or health care operations purposes within the past six years. This accounting will include the date the disclosure was made, the name of the person or entity the disclosure was made to, a description of the health plan information disclosed, the reason for the disclosure, and certain other information. If You request an accounting more than once in a 12-month period, there may be a reasonable cost-based charge for responding to those additional requests. Please contact the Privacy Office for a more detailed explanation of the fees charged for such accountings.
3. **RESTRICTION REQUESTS:** You have the right to request restrictions on the Employer's use or disclosure of Your health plan information. Employer is not required to agree to such requests. Employer will only restrict the use or disclosure of Your health plan information as set forth in a written agreement that is signed by a representative of the Privacy Office on behalf of the Employer.
4. **BREACH NOTICE:** You have the right to notice following a breach of unsecured protected health information. The notice of a breach of unsecured protected health information shall at a minimum include the following: The date of the breach, the type of data disclosed in the breach, who made the non-permitted access, use or disclosure of unsecured protected health information and who received the non-permitted disclosure, and what corrective business action was or will be taken to prevent further non-permitted access, uses or disclosures of unsecured protected health information.
5. **CONFIDENTIAL COMMUNICATIONS:** If You reasonably believe that sending health plan information to You in the normal manner will endanger You, You have the right to make a written request that the Employer communicate that information to You by a different method or to a different address. If there is an immediate threat, You may make that request by calling the Employer. Follow up with a written request is required

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

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

QUESTIONS AND COMPLAINTS

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

If You: (1) are concerned that the Employer has violated Your privacy rights; (2) disagree with a decision made about access to Your health plan information or in response to a request You made to amend or restrict the use or disclosure of Your health plan information; or (3) request that the Employer communicate with You by alternative means or at alternative locations; please contact the Privacy Office. You may also submit a written complaint to the U.S. Department of Health and Human Services. Employer will furnish the address where You can file a complaint with the U.S. Department of Health and Human Services upon request.

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

The Privacy Office

West Fraser, Inc.

1900 Exeter Road, Suite 105

Germantown, TN 38138-2954