BLUECROSS BLUESHIELD OF TENNESSEE
PERSONAL HEALTH COVERAGE

Policy No. xxxxxxxxxxxx
Effective Date – xx/xx/xxxx

NOTICE

Please read this Policy carefully and keep it in a safe place for future reference. It explains Your Coverage from BlueCross BlueShield of Tennessee. If You have any questions about this Policy or any matter related to Your membership with the Plan, please write or call Us at:

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

This Policy provides Coverage for reconstructive breast Surgery in certain situations. Please read Your Policy carefully.

You may return this Policy within ten (10) days after its delivery and receive a Premium refund if, after examination, You are not satisfied with it. Any benefits paid will be deducted from the Premium refund.

This Policy pays secondary to other individual or group insurance coverage.

You are responsible for obtaining Prior Authorization when using a Network Provider outside of Tennessee (BlueCard PPO Participating Provider) or an Out-of-Network Provider.

TTY: call 1-800-848-0299
Spanish: Para obtener ayuda en español, llame al 1-800-565-9140
Tagalog: Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-565-9140
Chinese: 如果需要中文的帮助，请拨打这个号码 1-800-565-9140
Navajo: Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-565-9140

G. Henry Smith
Senior Vice-President, Operations and Chief Marketing Officer

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Get the Most from Your Benefits

A. Please read Your Policy. “BlueCross,” “BlueCross BlueShield of Tennessee,” “Plan,” “Policy,” "Our," "Us" or "We" mean BlueCross BlueShield of Tennessee, Inc. “You” and “Your” mean a Subscriber. “Subscriber” means the individual to whom We have issued this Policy. “Member” means a Subscriber or a Covered Dependent. “Coverage” means the insurance benefits Members are entitled to under this Policy. This Policy describes the terms and conditions of Your Coverage and includes all attachments, which are incorporated herein by reference. This Policy replaces and supersedes any Policy that You may have previously received from Us.

Please read this Policy carefully. It describes Your rights and duties as a Subscriber/Member. It is important to read the entire Policy. Certain services are not Covered by Us. Other Covered Services are limited.

Any Grievance related to Coverage under this Policy must be resolved in accordance with the “MSPP Grievance Procedure” section of this Policy.

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

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

Your PPO plan has two levels of benefits. By using Network Providers, You receive the highest level of benefits. However, You can choose to use Providers that are not Network Providers. These Providers are called Out-of-Network Providers. When You use Out-of-Network Providers, Your benefits will be lower. You will also be responsible for amounts that an Out-of-Network Provider bills above Our Maximum Allowable Charge and any amounts not Covered by Your Plan.

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

By using Network Providers, You maximize Your benefits and avoid balance billing. Balance billing happens when You use an Out-of-Network Provider and You are billed the difference between the Provider’s price and the Maximum Allowable Charge. This amount can be substantial.

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

Our customer service number is on the back of Your Member ID card. This is an important phone number. Call this number if You have any questions. Also, call this number if You are receiving services from Providers outside of Tennessee or from Out-of-Network Providers to make sure all Prior Authorization procedures have been followed. See the “Prior Authorization, Care Management, Medical Policy and Patient Safety” section for more information.

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

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

   If Your doctor refers You to another doctor, hospital or other health care Provider, or You see a covering physician in Your doctor's practice, please make sure that the Provider is a Network Provider. When using Out-of-Network Providers, You will be responsible for the difference between the Provider's price and the Maximum Allowable Charge. This amount can be substantial.

E. **Ask Our consumer advisors** if the Provider is in the specific network shown on Your Member ID card. Since BlueCross has several networks, a Provider may be in one BlueCross network, but not in all of Our networks. Visit bcbst.com and use the Find a Doctor tool for more information on Providers in each network.

F. **To find out** if BlueCross considers a recommended service to be Medically Necessary, please refer to Our Medical Policy Manual at bcbst.com. Search for "Medical Policy Manual." The Medical Policy Manual includes determinations about whether a particular technology, service, drug, etc. is Medically Necessary or experimental/Investigational. Services that are experimental/Investigational or that are not Medically Necessary are not Covered; You and Your doctor decide what services You will receive, whether Covered by Us or not.

G. **Prior Authorization is required for certain services**. Reference the "Prior Authorization, Care Management, Medical Policy and Patient Safety" section for a partial list. Make sure Your Provider obtains Prior Authorization before any planned hospital stays (except maternity admissions), skilled nursing and rehabilitative facility admissions, certain outpatient procedures, Advanced Radiological Imaging services, and before ordering certain Specialty Drugs and certain durable medical equipment. Call Our consumer advisors to find out which services require Prior Authorization. You can also call Our consumer advisors to find out if Your admission or other service has received Prior Authorization.

H. **To save money** when getting a Prescription filled, **ask if a generic equivalent is available**.

I. In a true Emergency it is appropriate to go to an Emergency room **(see Emergency definition in the "Definitions" section of this Policy). However, most conditions are not Emergencies and are best handled with a call to Your doctor's office**.

J. Ask that Your Provider **report any Emergency admissions to BlueCross within 24 hours** or the next business day.

K. **Get a second opinion** before undergoing elective Surgery.

L. If You need assistance with symptom assessment, short term care decisions, or any health-related question or concern, connect with a nurse by calling Our 24/7 Nurseline or through web chat on *BlueAccess* at bcbst.com. The nurses can also assist with decision support and advice when contemplating Surgery, considering treatment options, and making major health decisions. Call 1-800-818-858, or for hearing impaired, TTY 1-888-308-7231.

M. **Notify** the Health Insurance Marketplace/Exchange at 800-318-2596 if changes in the following occur for You or any of Your Covered Dependents:

   a. Name;

   b. Address;

   c. Telephone number;

   d. Status of any other health insurance You might have;

   e. Birth of additional dependents;

   f. Marriage or divorce;

   g. Death;

   h. Adoption; or

   i. Citizenship status.

N. **Right to Receive and Release Information:** You authorize Our receipt, use and release of personal information for Yourself and all Covered Dependents. This authorization includes any and all medical records, obtained, used or released in connection with administration of the Policy, subject to applicable laws. Such authorization is deemed given by Your signature on the Application. Additional authorization and/or consent may be required whenever You obtain Covered Services under this Policy. This authorization remains in effect throughout the period You are Covered under this Policy. This authorization survives the termination of the Coverage to the extent that such information or records relate to services rendered while You were insured under the Policy.

   You may also be required to authorize the release of personally identifiable health information in connection with the administration of the Policy.

Enrolling in the Plan

A. **Open Enrollment Period**

You may apply to enroll in Coverage for You and Your dependents during this time period and elect new Coverage during this period in subsequent years.

B. **Limited Open Enrollment Periods and Special Enrollment Periods**

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

1. You or Your dependent loses Minimum Essential Coverage;
2. You gain a dependent or become a dependent through marriage, birth, adoption or placement for adoption;
3. You experience enrollment or non-enrollment in Coverage that is unintentional, inadvertent, or erroneous and is the result of an error, misrepresentation, or inaction of an officer, employee, or agent of the Health Insurance Marketplace/Exchange as determined by the Health Insurance Marketplace/Exchange. In such cases, the Health Insurance Marketplace/Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
4. You or Your dependent adequately demonstrates to the Health Insurance Marketplace/Exchange that BlueCross substantially violated a material provision of this Policy;
5. You are determined newly eligible or newly ineligible for Advanced Payments of the Premium Tax Credit (APTC) or You have a change in eligibility for Cost-Sharing Reductions (CSR);
6. You or Your dependent gains access to new Coverage as a result of a permanent move;
7. You or Your dependent, who were not previously a citizen, national, or lawfully present individual, gains such status;
8. You or Your dependent as an Indian, as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(d)) , may enroll in a Qualified Health Plan (QHP) or change from one QHP to another one time per month;
9. You or Your dependent demonstrates to the Health Insurance Marketplace/Exchange, in accordance with guidelines issued by the Department of Health and Human Services (HHS), that You or Your dependent meets other exceptional circumstances as the Health Insurance Marketplace/Exchange may provide.

You or Your dependent has sixty (60) days from the date of a triggering event, unless specifically stated otherwise, to enroll in or change enrollment in Coverage.

C. **Adding Dependents**

After You are Covered, You may apply to add a dependent who became eligible after You enrolled, as follows:

1. The following are custody events that permit adding children to the Coverage: Your or Your spouse's newborn child is Covered from the moment of birth. A legally adopted child, or a child for whom You or Your spouse has been appointed legal guardian by a court of competent

jurisdiction and the children are placed in Your physical custody, may be Covered under the Plan. You must enroll the child within sixty (60) days from the occurrence of the custody event.

If You fail to enroll the child, Your Policy will not cover the child after thirty-one (31) days from when You acquired the child. If the legally adopted (or placed) child has Coverage of his/her medical expenses from a public or private agency or entity, You may not add the child to Your Policy until that Coverage ends.

2. Any other new family dependent (e.g., if You marry) may be added as a Covered Dependent if You complete and submit a signed Application to the Health Insurance Marketplace/Exchange within sixty (60) days of the triggering event. The Health Insurance Marketplace/Exchange will determine if that person is eligible for Coverage.

D. **Notification of Change in Status**

You must submit an Application for eligibility to the Health Insurance Marketplace/Exchange if any changes occur in Your status, or the status of a Covered Dependent, within sixty (60) days from the date of the event causing that change. Such events include, but are not limited to, (1) marriage; (2) divorce; (3) death; (4) dependency status; (5) enrollment in Medicare; (6) coverage by another Payor; or (7) change of address.

When Coverage Begins

If You are eligible, have applied, and have paid the Premium, We will notify You of Your Effective Date.

A. **Open Enrollment Period**

For a Coverage selection made during the annual Open Enrollment Period as established by the Federal Government, Your Coverage Effective Date will be determined in accordance with federal regulations.

B. **Limited Open Enrollment Periods and Special Enrollment Periods**

Except as specified in section "C. Adding Dependents," for a change in Coverage selection associated with an eligible qualifying event received by the Health Insurance Marketplace/Exchange from You:

1. Between the first and fifteenth day of any month, You will receive a Coverage Effective Date of the first day of the following month; and
2. Between the sixteenth and the last day of any month, You will receive a Coverage Effective Date of the first day of the second following month.

C. **Adding Dependents**

For newborns, adoption, or placement of a child, Coverage will be effective as of the date of the qualifying event (i.e., birth, adoption or guardianship) or, upon request, either the first of the month following the qualifying event or as outlined in section "B. Limited Open Enrollment Periods and Special Enrollment Periods" if the dependent is enrolled within sixty (60) days of the qualifying event, and We receive any Premium required for Coverage.

In the event of marriage or loss of Minimum Essential Coverage, if the Application is received within sixty (60) days of the qualifying event and the Application is approved, and We receive any Premium required for Coverage, Coverage will be effective on the first day of the month following the qualifying event date and Coverage election.

D. **Premiums**

You must pay the Premiums due for Your Policy in full no later than thirty (30) calendar days from Your Effective Date unless We process Your enrollment after Your Effective Date. If We process Your enrollment after Your Effective Date, You must pay the Premiums no later than thirty (30) calendar days from the date We receive Your enrollment notice from the Health Insurance Marketplace/Exchange. Premiums must be received by Us. This Policy will not become effective until the initial Premium has been paid in full.

E. **Returned Check Fee**

You will be charged $25 for any check or draft not honored by Your financial institution.

When Coverage Ends

A. **Termination or Rescission of Policy**

Your Policy is guaranteed renewable, until the first of the following occurs:

1. We do not receive the required Premium for Your Coverage when it is due; or
2. You request to terminate the Policy and give the Health Insurance Marketplace/Exchange advance written notice. Termination will take place the first day of the month following Our receipt of such notice; or
3. You act in such a disruptive manner as to prevent or adversely affect Our ability to administer the Policy; or
4. You fail to cooperate with Us as required by this Policy; or
5. You move outside of Tennessee; or
6. You or Your Covered Dependent(s) have made a material misrepresentation of fact or committed fraud in connection with Coverage. This provision includes, but is not limited to, furnishing incorrect or misleading information or permitting the improper use of Your Member ID card. We may terminate or Rescind Coverage, at Our discretion, if You or Your Covered Dependent(s) have made an intentional misrepresentation or committed fraud in connection with Coverage. If the misrepresentation or fraud occurred before Coverage became effective, We may Rescind Coverage as of the effective date. If the misrepresentation or fraud occurred after Coverage became effective, We may Rescind Coverage as of the date misrepresentation of fraud first occurred. If We decide to Rescind Coverage, and if applicable, We will return all Premiums paid after the termination date less any claims paid after that date. If claims paid after the termination date are more than Premiums paid after that date, We have the right to collect that amount from You to the extent allowed by law. We will notify You thirty (30) days in advance of any Rescission; or
7. We decide to terminate the type of Coverage You have, for all persons who have a similar Policy, after offering You replacement Coverage; or
8. If We cease to offer Coverage in the individual market; or
9. The Health Insurance Marketplace/Exchange determines You are no longer eligible for Coverage in a QHP through the Health Insurance Marketplace/Exchange. The Health Insurance Marketplace/Exchange will notify You that You are no longer eligible for Coverage and the last day of Coverage will be the last day of the month following the month in which the Health Insurance Marketplace/Exchange notice was sent.

B. **Termination of Covered Dependent Coverage**

Your Covered Dependent's Coverage will automatically terminate on the earliest of the following dates:

1. The date that Your Coverage terminates; or
2. The last day of the month for which You paid Your Covered Dependent's Premium; or
3. The date a Covered Dependent is no longer eligible, (e.g., upon renewal, if the Covered Dependent has turned 26); or

4. The date a Covered Dependent enters active duty with the armed forces of any country.

C. **Exceptions to Covered Dependent Termination of Coverage**

Coverage for an intellectually/developmentally disabled or physically handicapped Covered Dependent will not stop due to age, if he or she is incapable of self-support and mainly dependent upon You at that time. Coverage will continue as long as:

1. You continue to pay the required Premium for the Covered Dependent's Coverage; and
2. Your own Coverage under the Policy remains in effect; and
3. You provide Us with required proof of the Covered Dependent's incapacity and dependency. Initial proof of the Covered Dependent's incapacity and dependency must be furnished to Us within 60 days of the Covered Dependent's attainment of the Limiting Age. We may require this proof again, but no more frequently than annually.

D. **Grace Period**

A grace period is a specific time after Your Premium is due, during which You can pay Your Premium, without a lapse in Coverage. The length of Your grace period depends on whether or not You receive Advanced Payments of the Premium Tax Credit (APTC) from the Federal Government.

1. **APTC (Tax Credit) Recipient**

You have a three-month grace period in which to pay all outstanding Premiums. During this grace period, Your Coverage will continue and claims for Covered Services incurred during the first month of the grace period will be processed. We may suspend payments to Providers rendering services to You and Your Covered Dependents during the second and third months of the grace period.

If You pay the Premium in full during the grace period, Your Coverage will continue and claims for Covered Services incurred during the grace period will be honored.

If You do not pay the Premium due, in full, by the end of the three-month grace period, Your Coverage will terminate the last day of the first month of the three-month grace period and You will be liable for Providers' charges for services rendered during the second and third months of the three-month grace period. We will keep any Premium payments made toward the first month's Premium during which You had Coverage and return all other Premium amounts attributable to the second or third months.

2. **Non-APTC (Tax Credit) Recipient**

You have a thirty-one (31) day grace period in which to pay Your Premium.

If You pay the Premium in full during the grace period, Your Coverage will continue and claims for Covered Services incurred during the grace period will be honored.

If You do not pay the Premium due, in full, during the grace period, Your Coverage will terminate retroactive to the Premium due date. We may suspend payments to Providers rendering services to You and Your Covered Dependents during the grace period. You will be liable for Providers' charges for services rendered during the grace period.

E. **Payment For Services Rendered After Termination of Coverage**

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

F. **Right to Request a Hearing**

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

General Provisions

A. **Entire Policy: Changes**

The Policy consists of (1) this Policy; (2) the Attachments; and (3) any other attached papers, including the Schedule of Benefits. The terms of this Policy can be changed only if (1) We agree in writing; and (2) one of Our authorized officers agrees to the change.

No agent or employee may change this Policy, or waive any of its provisions.

We may change the terms of the Policy when Your Policy renews. We will notify You in writing at least thirty (30) days before the date any change becomes effective. Your continued payment of Premiums indicates acceptance of a change. Any notice of change will be mailed to You at the address shown in Our records.

B. **Applicable Law**

The laws of Tennessee govern this Policy.

C. **Notices**

All notices required by this Policy must be in writing. Notices to Us should be addressed to:

BlueCross BlueShield of Tennessee
1 Cameron Hill Circle
Chattanooga, TN 37402-0002

We will send notices to You at the most recent address in Our files.

You are responsible for notifying the Health Insurance Marketplace/Exchange of Your and Your Covered Dependents' address changes.

D. **Legal Action**

No legal action shall be brought to recover under this Policy until sixty (60) days after proof of loss has been furnished. No such legal action shall be brought more than three (3) years after the time proof of loss is required.

E. **Right to Request Information**

We have the right to request any additional necessary information or records with respect to any Member Covered or claiming benefits under the Policy.

F. **Coordination of Benefits**

This is an individual Policy, not subject to the coordination of benefits regulation. If You or Your Covered Dependents have other coverage, whether group or individual, this Policy will always pay secondary. Other coverage means other comprehensive medical coverage and does not include limited benefit coverage. Benefits will be calculated as the difference between the amount paid by the other coverage and the greater of Our Maximum Allowable Charge or the amount such other coverage considers allowable expense.

If such other coverage also states that it will always pay secondary, benefits under this Policy will be calculated as 50% of Our Maximum Allowable Charge.

In any event, Our liability shall be limited to the amount We would have paid in the absence of other insurance.

G. **Benefits When Covered Under Medicare**

When a Member becomes covered under Medicare, the benefits under this Policy will be reduced so that the sum of benefits under Medicare and this Policy will not be greater than:

1. The Medicare Approved Amount for Providers who accept Medicare assignment; or
2. The total amount charged for Providers who do not accept Medicare assignment.

H. **Administrative Errors**

If We make an error in administering the benefits under this Policy, We may provide additional benefits or recover any overpayments from any person, insurance company, or plan. Any recovery must begin within eighteen (18) months (or the time frame allowed by law) from the date the claim was paid. This time limit does not apply if the Member did not provide complete information or if material misstatements or fraud have occurred.

No such error may be used to demand more benefits than those otherwise due under this Policy.

I. **Overinsurance Termination Provision**

We have the right to request information, in advance of Premium payment, about whether or not You are eligible for benefits under another group or individual contract, including:

1. Another hospital, surgical, medical or major medical expense insurance policy;
2. Any BlueCross and BlueShield plan; or
3. Any medical practice or other prepayment plan.

We also have the right to terminate this Policy if You fail to give correct information about other coverage.

J. **Time Limit on Certain Defenses**

After two (2) years from the Effective Date of this Policy, no intentional misrepresentations of a material fact, except fraudulent misstatements, made by the applicant in the Application for such Policy shall be used to void the Policy or to deny a claim for loss incurred after the expiration of such two (2) year period.

Prior Authorization, Care Management, Medical Policy and Patient Safety

BlueCross provides services to help manage Your care including performing Prior Authorization of certain services to ensure they are Medically Necessary, Concurrent Review of hospitalization, discharge planning, low-risk condition management, care coordination, complex and chronic care management and specialty care programs, such as transplant case management. BlueCross also develops and publishes medical policies.

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

A. **Prior Authorization**

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

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

1. Inpatient hospital stays (except maternity admissions);
2. Skilled nursing facility and rehabilitation facility admissions;
3. Certain outpatient Surgeries and/or procedures;
4. Certain Specialty Drugs;
5. Certain Prescription Drugs;
6. Advanced Radiological Imaging services;
7. Certain durable medical equipment (DME);
8. Certain prosthetics;
9. Certain orthotics;
10. Certain musculoskeletal procedures (including, but not limited to, spinal Surgeries, spinal injections, and hip, knee and shoulder Surgeries);
11. Other services not listed at the time of publication may be added to the list of services that require Prior Authorization. Visit bcbst.com or call Our consumer advisors at the number on the back of Your Member ID card to find out which services require Prior Authorization.

Network Providers in Tennessee will obtain 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 Network Providers outside Tennessee for physician and outpatient services and all services from Out-of-Network Providers, or payments may be reduced or services denied.

If Prior Authorization is required and not obtained, and services are Medically Necessary, benefits may be reduced for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Participating Providers). If the reduction results in liability to You greater than $2,500 above what You would have paid had Prior Authorization been obtained, then You may contact Our consumer advisors to have the claim reviewed and adjusted and the reduction will be limited to $2,500. Services that are not determined to be Medically Necessary are not Covered.

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

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

You are not held harmless if:

1. A Network Provider outside Tennessee (known as a BlueCard PPO Participating Provider) fails to comply with Our Care Management program(s); or
2. An Out-of-Network Provider fails to comply with Our Care Management program(s); or
3. You sign a Provider's waiver stating that You will be responsible for the cost of the treatment, according to the terms of the waiver.

B. **Care Management**

A number of Care Management programs are available to You across the care spectrum, including for low-risk health conditions, potentially complicated medical needs, chronic illnesses and/or complex illnesses or injuries. Registered nurses and health navigators work with You, Your family, Your doctors and other health care Providers to coordinate care, provide education and support, and to identify the most appropriate care setting. Depending on the level of Care Management needed, care managers maintain regular contact with You throughout treatment, coordinate clinical and health plan Coverage matters, and help You and Your family utilize available community resources.

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

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

Emerging Health Care Programs - Care Management is continually evaluating emerging health care programs. These are processes that demonstrate potential improvement in access, quality, efficiency, and Member satisfaction.

When We approve an emerging health care program, approved services provided through that program are Covered, even though they may normally be excluded under this Policy.

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

C. **Medical Policy**

Medical policies address new and emerging medical technologies. The goal is to make sure that Covered Services are safe, effective, and 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" include devices, procedures, medications and other emerging medical services.

Medical policies state whether or not a technology is Medically Necessary, Investigational or Cosmetic. As technologies change and improve, and as Members' needs change, We may reevaluate and change medical policies without formal notice. Visit bcbst.com to review Our medical policies. Enter "medical policy" in the Search field.

Medical policies sometimes define certain terms. If the definition of a term defined in Our medical policy differs from a definition in this Policy, 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 back of Your Member ID card. Your concern will be noted and investigated by Our Clinical Risk Management department.

Health and Wellness

BlueCross provides You with resources to help improve Your health and quality of life through Our interactive Health and Wellness Portal. To learn more about these resources, visit bcbst.com and click on the *Health & Wellness* tab, or call the number on the back of your Member ID card.

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

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

Self-Directed Health Courses – Our self-guided online health courses help to educate You about common health concerns and how to control them.

24/7 Nurseline – This feature provides You 24/7 access to nurses through telephone or web chat that can assist with symptom assessment, health-related questions or concerns and decision support. Connect to a nurse by phone at 1-800-818-8581, for hearing impaired TTY 1-888-308-7231 or through web chat on *BlueAccess* at bcbst.com.

BluePerks℠ – BluePerks is a discount program with savings of up to 50% on a range of health-related products and services, including fitness equipment, LASIK eye Surgery, massage therapy, hearing aids, travel and recreation, weight loss programs and more.

FitnessBlue℠ – FitnessBlue is a discount fitness program that is intended to help You get and stay fit with a nationwide network of fitness facilities.

Inter-Plan Programs

Out-of-Area Services

BlueCross BlueShield of Tennessee (“BlueCross”) has a variety of relationships with other Blue Cross and/or Blue Shield Licensees ("Inter-Plan Programs"). Whenever You obtain health care 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.

Typically, when accessing care outside the Service Area, You will obtain care from health care 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.

A. **BlueCard® PPO Program**

When You are outside the Service Area and need health care 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 obligations under this Policy. 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:

1. The Billed Charges for Your Covered Services; or
2. 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 health care Provider. Sometimes, it is an estimated price that takes into account special arrangements with Your health care 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 health care 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.

B. **Non-Participating Health Care Providers Outside BlueCross's Service Area**

1. 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.

2. Exceptions

In certain situations, BlueCross may use other payment bases, such as Covered Billed Charges, the payment We would make if the health care 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.

C. **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 or Your Covered Dependents receive Covered Services from a Network Provider, the Provider will submit a claim to Us. If You receive Covered Services from an Out-of-Network Provider, either You or the Provider must submit a claim form to Us. If You receive Covered Services from an Out-of-Network Pharmacy, You 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 current industry standards when We process claims.

A. **Claims**

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

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

B. **Claims Billing**

1. You should not be billed or charged for Covered Services rendered by Network Providers, except for required Member Payments. The Network Provider will submit the claim directly to Us.
2. You may be charged or billed by an Out-of-Network Provider for Covered Services rendered by that Provider. If You or Your Covered Dependents use an Out-of-Network Provider, You are responsible for the difference between the Provider's price and the Maximum Allowable Charge. You are also responsible for complying with any of Our medical management policies or procedures (including obtaining Prior Authorization of such services, when necessary).

   If You are charged or receive a bill to be reimbursed, You must submit the claim to Us within one (1) year and ninety (90) days from the date a Covered Service was received. If You do not submit a claim within the one (1) year and ninety (90) day time period, it will not be paid.
3. Claims for services received from Non-Contracted Providers are handled in the same manner as described above for Out-of-Network Providers.
4. You may request a claim form by contacting Our consumer advisors. We will send You a claim form within fifteen (15) days. You must submit proof of payment acceptable to Us with the claim form. We may also request additional information or documentation if it is reasonably necessary to make a Coverage Decision concerning a claim.

Mail all medical and dental claim forms to:

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

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

EyeMed Vision Care®
ATTN: OON CLAIMS
P.O. Box 8504
Mason, OH 45040

5. A Network Provider or an Out-of-Network Provider may refuse to render, or reduce or terminate a service that has been rendered, or require You to pay for what You believe should be a Covered Service.
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 or Your Covered Dependent(s) received Covered Services from a Network Provider, We will pay the Network Provider directly. These payments are made according to Our agreement with that Network Provider. You authorize assignment of benefits to that Network Provider. Covered Services will be paid at the Network Benefit level.
2. Out-of-Network Providers may or may not file claims for You or Your Covered Dependent(s). A completed claim form for Covered Services must be submitted in a timely manner. We will reimburse You, unless You have assigned benefits to the Provider. You will be responsible for the difference in the Billed Charges and the Maximum Allowable Charge. Our payment fully discharges Our obligation related to that claim.
3. Non-Contracted Providers may or may not file Your or Your Covered Dependents' 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 will be responsible for the difference between what the Plan pays and what the Non-Contracted Provider charges.
4. If this Policy is terminated, all claims for Covered Services rendered prior to the termination date must be submitted to Us within one (1) year and ninety (90) days from the date the Covered Services were received.
5. We will pay benefits within thirty (30) days after We receive a claim form that is complete. Claims are processed in accordance with current industry standards, and based on the information in Our possession at the time We receive the claim form. We are not responsible for overpayment or underpayment of claims if Our information is not complete or is inaccurate. We will make reasonable efforts to obtain and verify relevant facts when claim forms are submitted. Payment for Covered Services is more fully described in "Attachment C: Schedule of Benefits."
6. At least monthly, You will receive an Explanation of Benefits (EOB) that describes how a claim was treated. For example, the EOB shows how a claim was paid, denied, how much was paid to

the Provider, and will also let You know if You owe an additional amount to that Provider. We will make the EOB available to You at bcbst.com, or by calling Our consumer advisors at the number on the back of Your Member 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 Provider on Your behalf, We may collect those amounts directly from You.

D. **Assignment**

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

MSPP Grievance Procedure

A. Introduction

Our Grievance procedure is intended to provide a fair, quick and inexpensive method of resolving any and all Disputes with Us. Such Disputes include any matters that cause You to be dissatisfied with any aspect of Your relationship with Us; any Adverse Benefit Determination concerning a claim; or any other claim, controversy, or potential cause of action You may have against Us.

Please contact Our consumer advisors at the number on the back of Your Member ID card (1) to file a claim; (2) if You have any questions about this Policy or other documents related to Your Coverage (e.g. an Explanation of Benefits (EOB) or monthly claims statement); or (3) to initiate a Grievance concerning a Dispute.

1. The Grievance procedure can only resolve Disputes that are subject to Our control.
2. You cannot use this Grievance procedure to resolve a claim that a Provider was negligent. Network Providers are independent contractors. They are solely responsible for making treatment decisions in consultation with their patients. You may contact Us, however, to complain about any matter related to the quality or availability of services, or any other aspect of Your relationship with Providers.

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

1. If a Provider does not render a service, or reduces or terminates a service that has been rendered, or requires You to pay for what You believe should be a Covered Service, You may submit a claim to Us to obtain a determination concerning whether the Policy will cover that service. As an example, if a Pharmacy does not provide You with a prescribed medication or requires You to pay for that Prescription, You may submit a claim to Us to obtain a determination about whether it is Covered by the Policy. Providers may be required to hold You harmless for the cost of services in some circumstances.
2. Providers may also appeal an Adverse Benefit Determination through Our Provider dispute resolution procedure.
3. Our determination will not be an Adverse Benefit Determination if (1) a Provider is required to hold You harmless for the cost of services rendered; or (2) until We have rendered a final Adverse Benefit Determination in a matter being appealed through the Provider dispute resolution procedure.

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

The Plan and You may agree to skip one or more of the steps of this Grievance procedure if it will not help to resolve Our Dispute.

Any Dispute will be resolved in accordance with applicable Tennessee or federal laws and regulations, and this Policy.

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 a consumer advisor 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. **Grievance**

You must submit a written request asking Us to reconsider an Adverse Benefit Determination, or take a requested action to resolve another type of Dispute (Your "Grievance"). You must explain why (in terms of the applicable Policy coverage provisions) You feel the services should be Covered. Include copies of documents that support Your claim, such as physician letters, operative reports, bills, medical records and Explanation of Benefit (EOB) forms. You must begin the Dispute process within one-hundred and eighty (180) days from the date We issue notice of an Adverse Benefit Determination or from the date of the event that is otherwise causing You to be dissatisfied with Us. If You do not initiate a Grievance within one-hundred and eighty (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 Our consumer advisors at the number on the back of Your Member ID card for assistance in preparing and submitting Your Grievance. They can provide You with the appropriate form to use in submitting a Grievance. This is the first level Grievance procedure and is mandatory.

a. **Grievance Hearing**

After 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. The committee or reviewers have full discretionary authority to make eligibility, benefit and/or claim determinations, pursuant to the Policy.

b. **Written Decision**

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

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

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

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

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

i. A statement of the committee’s understanding of Your Grievance;

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

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

C. Independent External Review

If You are not satisfied with the first level Grievance decision, You may request that the Dispute be submitted to an independent external review through the U.S. Office of Personnel Management (OPM). Your request for independent external review must be submitted in writing within one (1) year from the date You receive an Adverse Benefit Determination.

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

Requests for independent external review should be submitted to the U.S. Office of Personnel Management at the following address:

MSPP External Review
National Healthcare Operations
U.S. Office of Personnel Management
1900 E Street, NW
Washington, DC 20415
1-(855) 318-0714
1-(202) 606-0033 FAX
mspp@opm.gov

All requests for independent external review will be handled as quickly as possible. However, if Your situation is urgent, Your request will be handled within seventy-two (72) hours of its receipt. Generally, an urgent situation is one that concerns an admission, availability of care, continued stay, or health care service for which You have received Emergency services, but have not been discharged. A situation is also urgent if the standard external review timeframe would seriously jeopardize Your life, health, or ability to regain maximum function. You may request an expedited independent external review by sending an attestation from Your doctor with the request for independent external review. In expedited cases, You may request that the Dispute be submitted for an independent external review at the same time You file Your Grievance.

You or someone You name to act for You (Your authorized representative) may file a request for independent external review.

OPM's jurisdiction for external review purposes encompasses appeals concerning medical judgment, contractual Disputes, and Rescissions. If You file a request for independent external review, OPM will review the Plan's decision. If Your claim was denied as not Medically Necessary, OPM will seek the binding opinion of an independent review organization. If Your claim was denied on Coverage under Your Policy, OPM will render a binder determination.

For additional information on the independent external review process through OPM, visit their website at http://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/.

No legal action shall be brought to recover under this Policy until sixty (60) days after proof of loss has been furnished. No such legal action shall be brought more than three (3) years after the time proof of loss is required.

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.

Legal Obligations

BlueCross BlueShield of Tennessee, Inc. and some subsidiaries and affiliates (BlueCross) are required to (1) 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 Our "legal obligations"); (2) provide this notice of privacy practices to You; (3) inform You of Our legal obligations; and (4) advise You of additional rights concerning Your health plan information. We must follow the privacy practices contained in this notice from its effective date, until this notice is changed or replaced.

We reserve the right to change privacy practices and the terms of this notice at any time, as permitted by Our 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 Our privacy practices.

You may request a copy of this notice of privacy practices at any time by contacting BlueCross BlueShield of Tennessee at the Privacy Office address listed at the end of this section.

Organizations Covered By This Notice

This notice applies to the privacy practices of BlueCross BlueShield of Tennessee, Inc. and its subsidiaries or affiliated covered entities. Health plan information about Our Subscribers and Members may be shared with each other as needed for treatment, payment or health care operations.

Uses and Disclosures of Health Plan Information

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

Treatment: Your health plan information may be disclosed to a health care Provider that asks for it to provide treatment.

Payment: Your health plan information may be used or disclosed to pay claims for services or to coordinate benefits, which are Covered under Your health insurance Policy.

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.

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. We cannot use or disclose Your health plan information except those described in this notice, without Your written authorization. Examples of where an authorization would be required are (1) most uses and disclosures of psychotherapy notes (if recorded by a covered entity); (2) uses and disclosures for

marketing purposes; (3) disclosures that constitute a sale of PHI; and (4) other uses and disclosures not described in this notice.

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 We may do so, as described in the "Individual Rights" section of this notice.

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.

Research: Your health plan information may be used or disclosed for research purposes, as allowed by law.

Your Death: If You die, Your health plan information may be disclosed to a coroner, medical examiner, funeral director or organ procurement organization.

As Required By Law: Your health plan information may be used or disclosed as required by state or federal laws.

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.

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.

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

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, We 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. We will require advance payment before copying Your health plan information.

Accounting of Disclosures: You have the right to receive an accounting of any disclosures of Your health plan information made by Us 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 twelve (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.

Restriction Requests: You have the right to request restrictions on Our use or disclosure of Your health plan information. We are not required to agree to such requests. **We 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 BlueCross BlueShield of Tennessee.**

Breach Notice: You have the right to notice following a breach of unsecured protected health information (PHI). The notice of a breach of unsecured protected health information (PHI) 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 (PHI).

Confidential Communications: If You reasonably believe that sending confidential health plan information to You in the normal manner will endanger You, You have the right to make a written request that We 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 a consumer advisor or the Privacy Officer at 1-888-455-3824. Follow up with a written request is required as soon as possible.** We 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 Policy.

Amendment Requests: You have the right to make a written request that We amend Your health plan information. **Your request must explain why the information should be amended**. We may deny Your request if the health plan information You seek to amend was not created by Us or for other reasons permitted by Our legal obligations. If Your request is denied, We 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 We accept 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.

Right to Request Written Notice: If You receive this notice on Our website or by electronic mail (email), You may request a written copy of this notice by contacting the Privacy Office.

Questions and Complaints

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

If You are concerned that (1) We have violated Your privacy rights; (2) You 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) to request that We 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. We will furnish the address where You can file a complaint with the U.S. Department of Health and Human Services upon request.

We support 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 BlueCross BlueShield of Tennessee or subsidiaries or affiliates, or with the U.S. Department of Health and Human Services.

BlueCross BlueShield of Tennessee
The Privacy Office
1 Cameron Hill Circle
Chattanooga, TN 37402
1-(888) 455-3824
(423) 535-1976 FAX
privacy_office@bcbst.com

General Legal Provisions

The Plan is an Independent Licensee of the BlueCross BlueShield Association

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

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

This paragraph shall not create any additional obligations on the part of BlueCross other than those created under this Policy.

Relationship with Network Providers

Network Providers are independent contractors and are not Our employees, agents or representatives. Network Providers contract with Us and We have agreed to pay them for rendering Covered Services to You. Network Providers are solely responsible for making all medical treatment decisions in consultations with their Member-patients. We do not make medical treatment decisions under any circumstances.

We have the discretionary authority to make benefit or eligibility determinations and interpret the terms of Coverage under this Policy ("Coverage Decisions"). We make those Coverage Decisions based on the terms of this Policy, Our benefit policies, other relevant sources of information, Our participation agreements with Network Providers and applicable state or federal laws.

We have participation agreements with the Network Providers. These permit Network Providers to dispute Our Coverage Decisions if they disagree with those decisions. If Your Network Provider does not dispute a Coverage Decision, You may request reconsideration of the Coverage Decision as explained in the "MSPP Grievance Procedure" section of this Policy. The participation agreement requires Network Providers to fully and fairly explain Coverage Decisions to You, upon request, if You decide to request that We reconsider a Coverage Decision.

The Plan 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 Policy. We do not promise that any specific Network Provider will be available to render services while You or Your Covered Dependents are Covered by this Policy.

Continuity of Care

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

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

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

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, health insurance issuers offering health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section. However, the 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, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the forty-eight (48) hour (or ninety-six (96) hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, an issuer may not, under federal law, require that a physician or other health care Provider obtain Authorization for prescribing a length of stay of up to forty-eight (48) hours (or ninety-six (96) hours). However, to use certain Providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain precertification. For information on precertification, contact Us.

Women's Health and Cancer Rights Act of 1998

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

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

The Coverage may be subject to Coinsurance and Deductibles consistent with those established for other benefits. Please refer to the body of this Policy or call Our consumer advisors for more details.

Governing Laws

Tennessee laws govern Your benefits.

Subrogation and Right of Recovery

You agree that We shall be subrogated to and/or have the right to recover amounts paid to provide Covered Services to You and Your Covered Dependent(s) for illnesses or injuries caused by third parties, including the right to recover the reasonable value of services rendered by Network Providers.

We shall have first lien against any payment, judgment or settlement of any kind that You or Your Covered Dependent(s) receives from or on behalf of such third parties for medical expenses, for the costs of Covered Services and any costs of recovering such amounts from those third parties. We may notify those parties of its lien without notice to or consent from You or Your Covered Dependent(s).

We may enforce Our 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.

To enable Us to protect Our rights under this section, You or Your Covered Dependent(s) shall be required to promptly notify Us if an illness or injury is caused by a third party. You or Your Covered Dependent(s) are also required to cooperate with Us and to execute any documents that We deem necessary to protect Our rights under this section.

If You or Your Covered Dependent(s) settles any claim or action against any third party without Our consent, You or Your Covered Dependent(s) shall be deemed to have been made whole by the settlement, and We shall be entitled to immediately collect the present value of Our rights as a first priority claim from the settlement fund. Any such proceeds of settlement or judgment shall be held in trust by You or Your Covered Dependent(s) for Our benefit. We shall also be entitled to recover reasonable attorneys' fees incurred in collecting proceeds held by You or Your Covered Dependent(s) in such circumstances.

Definitions

Defined terms are capitalized. When defined words are used in this Policy, they have the meaning set forth in this section. Words that are defined in the Plan's medical policies and procedures have the same meaning if used in this Policy.

1. **Acute** - An illness or injury that is both severe and of short duration.

2. **Advanced Payments of the Premium Tax Credit (APTC)** - Payment of the tax credits specified in section 36B of the Internal Revenue Code (as added by section 1401 of the Affordable Care Act) which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through a(n) Health Insurance Marketplace/Exchange.

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

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

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

   b. The denial, 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. **Affordable Care Act (ACA) –** The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152).

6. **Application** – A form that must be completed in full before You or Your dependents will be considered for Coverage under the Policy.

7. **Application Change Form** – A form that must be completed to make a change in Your Coverage under the Policy. Changes can include adding or terminating dependents or a change in Your level of Coverage. This form is also used to make administrative changes, such as a change in name or address.

8. **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.

9. **Billed Charges** – The amount that a Provider or Dentist charges for services rendered. Billed Charges may be different from the amount that We determine to be the Maximum Allowable Charge for services.

10. **BlueCard PPO Participating Provider** – A physician, hospital, licensed skilled nursing facility, home health care Provider or other Provider who contracts with other BlueCross and/or BlueShield Plans, BlueCard PPO Plans and/or whom We have Authorized to provide Covered Services to Members.

11. **BlueCross, BlueCross BlueShield of Tennessee, Plan, Policy, Our, Us, or We** – BlueCross BlueShield of Tennessee, Inc.

12. **Brand Deductible -** The amount that must be paid by You before benefits are provided for Preferred Brand Drugs or Non-Preferred Brand Drugs under this Policy. The Brand Deductible will not apply toward satisfying any other Deductible.

13. **Calendar Year** - The period of time beginning at 12:01 A.M. on January 1st and ending 12:00 A.M. on the following December 31st.

14. **Care Management** – A program that promotes cost-effective coordination of care for Members with complicated medical needs, chronic illnesses, and/or catastrophic illnesses or injuries.

15. **CHIP** – The State Children's Health Insurance Program established under title XXI of the Social Security Act (42 U.S.C. 1396 et. seq.).

16. **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.

17. **Coated Lenses or Coating** – A substance added to a finished lens on one or both surfaces.

18. **Coinsurance** – Sharing of the cost of Covered Services by the Plan and You, after Your Deductible has been satisfied. The Plan's Coinsurance amounts for network and out-of-network Covered Services are specified in "Attachment C: Schedule of Benefits." Your Coinsurance is calculated as 100% minus the Plan's Coinsurance. In addition to Your Coinsurance, You are responsible for the difference between the Billed Charge and the Maximum Allowable Charge if the Billed Charge of a Non-Contracted Provider or an Out-of-Network Provider is more than the Maximum Allowable Charge for such services.

Coinsurance applies to the Maximum Allowable Charge for Covered Services. For example, if the Out-of-Network Provider's Billed Charge is $5,000 and the Maximum Allowable Charge for Network Providers is $3,000, the Coinsurance percentage is based upon $3,000, not $5,000. In this example, You are responsible for the $2,000 charge difference plus Your Coinsurance on the $3,000 Maximum Allowable Charge.

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

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

20. **Compound Drug** - An outpatient Prescription Drug which is not commercially prepared by a licensed pharmaceutical manufacturer in a dosage form approved by the Food and Drug Administration (FDA) and that contains at least one ingredient classified as a Legend Drug.

21. **Concurrent Review** – The process of evaluating care during the period when Covered Services are being rendered.

22. **Copayment –** The dollar amount specified in "Attachment C: Schedule of Benefits" that You are required to pay directly to a Provider or Network Pharmacy for certain Covered Services. You must pay such Copayments at the time You receive those services.

23. **Cosmetic or 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.

24. **Cost-Sharing Reductions (CSR) –** Reductions in cost sharing, any expenditure required by or on behalf of an enrollee with respect to essential health benefits, for an eligible individual enrolled in a silver level plan in the Health Insurance Marketplace/Exchange or for an individual who is an Indian (as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(d))) enrolled in a QHP in the Health Insurance Marketplace/Exchange.

25. **Covered Dependent** - A Subscriber's family member who (1) meets the eligibility requirements of this Policy; (2) has been enrolled for Coverage; and (3) for whom We have received the applicable Premium for Coverage.

26. **Covered Family Members** - A Subscriber and his or her Covered Dependents.

27. **Covered Services, Coverage or Covered** - Those Medically Necessary and Appropriate services and supplies that are set forth in Attachments A-C of this Policy. Covered Services are subject to all the terms, conditions, exclusions and limitations of this Policy.

28. **Custodial Care** - Any services or supplies provided to assist an individual in the activities of daily living as determined by Us. This includes, but is not limited to eating, bathing, dressing or other self-care activities.

29. **Deductible** - The dollar amount, specified in "Attachment C: Schedule of Benefits" that You must incur and pay for Covered Services during a Calendar Year before We provide benefits for services. If a claim includes dates of service that span two Calendar Years, benefits may be subject to a Deductible for each Calendar Year. There are separate Deductible amounts for Network Providers and for Out-of-Network Providers. The Deductible(s) will apply to the Out-of-Pocket Maximum(s).

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

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

31. **Dispute or Grievance –** Any matters that cause You to be dissatisfied with any aspect of Your relationship with Us; any Adverse Benefit Determination concerning a claim; or any other claim, controversy, or potential cause of action You may have against Us.

32. **Effective Date** - The date Your Coverage under this Policy begins.

33. **Eligible Providers** - All services must be rendered by a Practitioner or Provider type listed in the Plan's Provider Directory of Network Providers, or as otherwise required by Tennessee law. The services provided by a Practitioner must be within his/her/its specialty, degree, licensure or accreditation. 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/her/its licensure.

34. **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 the prudent layperson's health in serious jeopardy.

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

35. **Emergency Care Services** - Those services and supplies that are Medically Necessary and Appropriate in the treatment of an Emergency and delivered in a hospital Emergency department.

36. **Essential Drug Formulary** - A list of specific generic and brand name Prescription Drugs covered by the Plan subject to Quantity Limitations, Prior Authorization, Step Therapy, over-the-counter alternative limitations and generic equivalent or therapeutic alternative limitations. The Essential Drug Formulary is subject to periodic review and modification at least annually by the Plan's Pharmacy and Therapeutics Committee. The Essential Drug Formulary is available for review at bcbst.com, or by calling the number on the back of Your Member ID card.

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

38. **Generic Drug** - A Prescription Drug that has the same active ingredients, strength or concentration, dosage form and route of administration as a Preferred or Non-Preferred Brand Drug. The FDA approves each Generic Drug as safe and effective as a specific Preferred or Non-Preferred Brand Drug.

39. **Habilitative Therapy** - Therapies or other treatments that enable a person with a disability to attain functional abilities, or lessen the deterioration of function over time.

40. **Health Insurance Marketplace/Exchange** – A governmental agency or non-profit entity that meets the applicable standards under the Affordable Care Act and makes Qualified Health Plans (QHPs) available to qualified individuals.

41. **Hospital Confinement**– When You or Your Covered Dependent(s) are treated as a registered bed patient at a hospital or other Provider facility and incur a room and board charge.

42. **Hospital Services** - Covered Services that are Medically Appropriate to be provided by an Acute care hospital.

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

If the child reaches this Plan's Limiting Age while Covered under this Plan, proof of such incapacity and dependency must be furnished within 60 days of when the child reaches the Limiting Age.

We may ask You to furnish proof of the incapacity and dependency upon enrollment and for proof that the child continues to meet the conditions of incapacity and dependency, but no more frequently than annually.

44. **Indian Health Provider** – A Provider associated with the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization that renders Covered Services to a Member that is an Indian

(as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(d))).

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

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

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

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

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

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

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

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

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

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

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

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

a. Your medical records; or

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

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

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

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

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

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

46. **Legend Drugs** – A drug that, by law, can be obtained only by Prescription and bears the label, "Caution: Federal law prohibits dispensing without a Prescription."

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

48. **Mail Order Network** – BlueCross's network of mail service Pharmacy facilities.

49. **Maintenance Care** – Medical services (including skilled services and therapies), Prescription Drugs not received at a Pharmacy, supplies and equipment for chronic, static or progressive medical conditions where the services (including skilled services and therapies), Prescription Drugs, supplies and equipment (1) fail to contribute toward a 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 Prescription Drugs used to treat chemical and methadone dependency maintenance.

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

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

b. Test strips for blood glucose monitors;

c. Visual reading and urine test strips;

d. Insulin;

e. Injection aids;

f. Syringes;

g. Lancets;

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

i. Oral hypoglycemic agents;

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

k. Glucagon Emergency kits.

51. **Maximum Allowable Charge** – The amount that We, at Our discretion, have determined to be the maximum amount payable for a Covered Service. For Covered Services provided by Network Providers, that determination will be based upon Our contract with the Network Provider for Covered Services rendered by that Provider. For Covered Services provided by Out-of-Network Providers, the amount payable will be based on Our out-of network fee schedule for the Covered Services rendered by Out-of-Network Providers. For out-of-network Emergency Care Services, the Maximum Allowable Charge for a Covered Service complies with the Affordable Care Act requirement to be based upon the greater of (1)

the median amount negotiated with Network Providers for the Emergency Care Services furnished; (2) the amount for the Emergency Care Services calculated using the same method generally used to determine payments for out-of-network services; or (3) the amount that would be paid under Medicare for the Emergency Care Services.

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

53. **Medical Director** - The physician designated by Us, or that physician's designee, who is responsible for the administration of Our medical management programs, including its authorization program.

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

a. Be Medically Necessary;

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

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

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

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

55. **Medically Necessary or Medical Necessity** – Procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical Practitioner, exercising prudent clinical judgment, would provide to a 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;

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

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.

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

57. **Member, You, Your** - Any person enrolled as a Subscriber or Covered Dependent under this Policy.

58. **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.

59. **Minimum Essential Coverage –** Coverage under any of the following, as defined in section 5000A(f) of the Internal Revenue Code: (1) government-sponsored programs; (2) an eligible employer-sponsored

plan; (3) a health plan offered in the individual market within a state; (4) a grandfathered health plan; (5) other health benefits coverage, such as a state health benefits risk pool.

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

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

62. **Network Dentist** – A Dentist who has signed a preferred dental agreement with the Plan.

63. **Network Pharmacy** - A Pharmacy that has entered into a Network Pharmacy agreement with the Plan or its agent to legally dispense Prescription Drugs to You, either in person or through mail order.

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

65. **Non-Contracted Provider** – A Provider that renders Covered Services to a Member, but is in a specialty category or type with which We do not contract. A Non-Contracted Provider is different from an Out-of-Network Provider. A Non-Contracted Provider is not eligible to hold a contract with Us. Provider types that are considered non-contracted can change as We contract with different Provider types. 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.

66. **Non-Preferred Brand Drug or Elective Drug** - A Prescription Drug identified by its registered trademark or product name given by its manufacturer, labeler or distributo**r** that is not considered a Preferred Brand Drug by the Plan. Usually there are lower cost alternatives to some Non-Preferred Brand Drugs.

67. **Open Enrollment Period** – The period, as defined by the Department of Health and Human Services (HHS), in which individuals can select a choice of Coverage.

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

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

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

71. **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 temporomandibular joint syndrome or dysfunction (TMJ or TMD) by stabilizing the jaw joint. An Oral Appliance is not the same as an occlusal splint, which is used to treat malocclusion or misalignment of teeth.

72. **Out-of-Network Pharmacy** - A Pharmacy that has not entered into a service agreement with BlueCross or its agent to provide benefits under this Policy at specified rates to You.

73. **Out-of-Network Provider** – Any Provider who is an Eligible Provider type but who does not hold a contract with Us to provide Covered Services.

74. **Out-of-Pocket Maximum** - The total dollar amount, as stated in "Attachment C: Schedule of Benefits," that You must incur and pay for Covered Services during the Calendar Year, including Copayments, Deductible and Coinsurance. There are two (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) will not be considered when determining if an Out-of-Pocket Maximum has been satisfied.

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

When the out-of-network Out-of-Pocket Maximum is satisfied, benefits are payable at 100% for expenses for other Covered Services incurred by You during the remainder of that Calendar Year, excluding Penalties and any balance of charges (the difference between Billed Charges and the Maximum Allowable Charge).

75. **Oversized Lens –** Any lens with an eye size of 61mm or greater.

76. **Payor(s)** - An insurer, health maintenance organization, no-fault liability insurer, self-insurer or other entity that provides or pays for Your health care benefits.

77. **Penalty/Penalties** – A reduction in benefit amounts paid by Us as a result of failure to comply with Plan requirements such as failing to obtain Prior Authorization for certain Covered Services shown in "Attachment C: Schedule of Benefits," as requiring such Prior Authorization. The Penalty will be a reduction in Plan payment for Covered Services.

78. **Pharmacy** - A state or federally licensed establishment that is physically separate and apart from the office of a physician or authorized Practitioner, and where Legend Drugs are dispensed by Prescription by a pharmacist licensed to dispense such drugs and products under the laws of the state in which he or she practices.

79. **Pharmacy and Therapeutics Committee or P&T Committee** - A panel of Our participating pharmacists, Network Providers, Medical Directors and Pharmacy directors that reviews medications for safety, efficacy and cost-effectiveness. The P&T Committee evaluates medications for addition and deletion from the (1) Essential Drug Formulary; (2) Preferred Brand Drug list; (3) Prior Authorization Drug list; and (4) Quantity Limitation list. The P&T Committee may also set dispensing limits on medications.

80. **Practitioner –** A person licensed by the state to provide medical services.

81. **Preferred Brand Drug** - Brand name drugs that We have reviewed for clinical appropriateness, safety, therapeutic efficacy, and cost-effectiveness. The Preferred Brand Drug list is reviewed at least annually by the P&T Committee.

82. **Premium** - The total payment for Coverage under the Policy.

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

84. **Prescription Contraceptive Drugs** - Prescription Drug products that are indicated for the prevention of pregnancy.

85. **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.

86. **Preventive Health Exam** – An assessment of a patient's health status at intervals set forth in Our Medical Policy Manual for the purpose of maintaining health and detecting disease in its early state. This assessment should include:

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 preventive screening tests per Our medical policy.

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

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

89. **Provider** – A person or entity that is engaged in the delivery of health services or that is licensed, certified or practicing in accordance with applicable state or federal laws.

90. **Qualified Health Plan (QHP)** – A health plan that has in effect a certification that it meets the standards under the Affordable Care Act and is issued or recognized by the Health Insurance Marketplace/Exchange through which such plan is offered.

91. **Qualified Medical Child Support Order** – A medical child support order issued by a court of competent jurisdiction that creates or recognizes the existence of a child's right to receive benefits for which a Subscriber is eligible under this Policy. 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.

92. **Quantity Limitation or Quantity Limits** – Quantity Limitations applied to certain Prescription Drug products as determined by the P&T Committee.

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

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

94. **Select90 Network** – BlueCross's network of retail Pharmacies that are permitted to dispense Prescription Drugs to BlueCross Members on the same terms as Pharmacies in the Mail Order Network.

95. **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 Plan's Specialty Drug list. Specialty Drugs are categorized as Provider-administered or self-administered.

96. **Specialty Pharmacy Network** - A Pharmacy that has entered into a Network Pharmacy agreement with the Plan or its agent to legally dispense self-administered Specialty Drugs to You.

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

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

99. **Subscriber, You, Your** – An individual who meets all applicable eligibility requirements, has applied for Coverage, for whom We have received the applicable Premium for Coverage and to whom We have issued the Policy.

100.**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.

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

102.**Transplant Maximum Allowable Charge (TMAC)** - The amount that We, in Our discretion, have determined to be the maximum amount payable for Covered Services for organ transplants. Each type of organ transplant has a separate TMAC.

103.**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.

104.**Transplant Network Institution** – A facility or hospital that has contracted with Us (or with an entity on Our behalf) to provide Transplant Services for some or all organ and bone marrow transplant procedures Covered under this Policy. For example, some hospitals might contract to perform heart transplants, but not liver transplants. A Transplant Network Institution is a Network Provider when performing contracted transplant procedures in accordance with the requirements of this Policy.

105.**Transplant Service** - Medically Necessary and Appropriate services listed as Covered under the "Organ Transplants" section in "Attachment A: Covered Services and Exclusions" of this Policy.

106.**Vision Examination** – A Vision Examination or comprehensive ophthalmologic service describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmologic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated, biomicroscopy, examination with cyclopedia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs.

107.**Well Woman Exam** – A routine visit every Calendar Year to a Provider. The visit may include Medically Necessary and Medically Appropriate mammogram and cervical cancer screenings.

Attachment A: Covered Services and Exclusions

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

To be eligible for benefits, all services or supplies must be provided in accordance with Our medical policies and procedures. See the "Prior Authorization, Care Management, Medical Policy and Patient Safety" section for more information.

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

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

Please also read "Attachment B: Other Exclusions."

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

Out-of-Network Providers do not have a contract with Us. This means they may be able to charge You more than the Maximum Allowable Charge (the amount set by Us in Our contracts with Network Providers). When You use an Out-of-Network Provider for Covered Services, You will be responsible for any difference between the Provider's price and the Maximum Allowable Charge. **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 Our medical policy and Care Management 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 this Policy must be satisfied before benefits for Covered Services will be provided. Our medical policies can help Your Provider determine if a proposed service will be Covered.

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

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

A. **Ambulance Services**

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

1. Covered Services

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

    b. Medically Necessary and Appropriate treatment at the scene (paramedic services) without ambulance transportation.

    c. Medically Necessary and Appropriate ground transport when Your condition requires basic or advanced life support.

2. Exclusions

    a. Transportation for Your convenience.

    b. Transportation that is not essential to reduce the probability of harm to You.

B. **Behavioral Health**

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. Prior Authorization is required for:

    a. All inpatient levels of care, which include Acute care and residential care.

    b. Partial hospitalization programs.

    c. Intensive outpatient treatment programs.

    d. Certain outpatient Behavioral Health Services, including but not limited to electro-convulsive therapy (ECT).

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

2. Covered Services

    a. Inpatient services for care and treatment of behavioral/mental health disorders and substance abuse disorders.

    b. Outpatient facility services, including partial hospitalization and intensive outpatient treatment programs for treatment of behavioral/mental health disorders and substance abuse disorders.

    a. Practitioner office visits for care and treatment of behavioral/mental health disorders and substance abuse disorders.

3. 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-10 diagnostic classification, such as adult child of alcoholics (ACOA), and co-dependency and self-help programs.

    f. Sleep disorders.

    g. Services related to intellectual/developmental disabilities.

    h. Court ordered examinations and treatment, unless Medically Necessary.

    i. Pain management.

    j. Hypnosis or regressive hypnotic techniques.

C. **Dental Services – Medically Necessary for all Members**

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. For Pediatric Dental benefits, see the "Dental Services – Pediatric Dental" section.

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 three (3) months and completed within twelve (12) months of the accident.

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

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

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

        iii. Mental illness or behavioral condition that precludes dental Surgery in the office;

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

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

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

2. Exclusions

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

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

    c. Extraction of impacted teeth, including wisdom teeth.

D. **Dental Services - Orthodontia - Pediatric Only**

Orthodontia when performed in conjunction with Medically Necessary and Appropriate orthognathic Surgery for Members under age nineteen (19). Prior Authorization for Medically Necessary orthodontia must be obtained from the Plan, or benefits will be reduced or denied.

1. Covered

    a. Medically Necessary and Appropriate non-Cosmetic orthodontia when performed in conjunction with orthognathic Surgery for Members under age nineteen (19).

2. Exclusions

    a. Orthodontia for Members age nineteen (19) and older.

    b. Cosmetic orthodontia.

E. **Dental Services – Pediatric Dental**

This “Dental Services - Pediatric Dental” section provides a wide range of benefits to Cover most services associated with dental care for dependents under age nineteen (19).

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

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

I. **Diagnostic Services**

A. **Exams**

1. Covered

    a. Standard exams including comprehensive, periodic, detailed/extensive limited and periodontal oral evaluations (exams).

2. Limitations

    a. No more than one (1) standard exam in any six (6) month period.

3. Exclusions

    a. Re-evaluations and consultations.

B. **X-rays**

1. Covered

    a. Full mouth series, intraoral and bitewing radiographs (x-rays).

2. Limitations

    a. No more than one (1) full mouth set of x-rays in any sixty (60) month period. A full mouth set of x-rays is defined as either an intraoral complete series or panoramic x-ray. Benefits provided for either include benefits for all necessary intraoral and bitewing films taken on the same day.

    b. No more than four (4) bitewing films in any six (6) month period. Bitewing films must be taken on the same date of service.

3. Exclusions

    a. Extraoral, skull and bone survey, sialography, and tomographic survey x-ray films, cephalometric films and diagnostic photographs.

II. **Preventive Services**

A. **Prophylaxis (Cleanings)**

1. Covered

    a. Child prophylaxis (cleaning) for primary and permanent teeth.

2. Limitations

    a. No more than one (1) of any prophylaxis or periodontal maintenance procedure in any six (6) month period.

    b. Periodontal maintenance procedures are subject to additional limitations listed below under Basic Periodontics, and may be subject to a different Coverage level under “Attachment C: Schedule of Benefits.”

B. **Fluoride Treatment**

1. Covered

    a. Topical fluoride treatments, performed with or without a prophylaxis.

2. Limitations

    a. No more than one (1) fluoride treatment in any six (6) month period.

    b. Fluoride must be applied separately from prophylaxis paste.

C. **Other Preventive Services**

1. Covered

    a. Sealants, preventive resin restorations, space maintainers.

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

2. Limitations

    a. No more than one (1) sealant, preventive resin restoration, or resin infiltration per first or second molar tooth per thirty-six (36) months. Resin infiltrations are subject to a different Coverage level under "Attachment C: Schedule of Benefits."

    b. No more than one (1) re-cementation in any twelve (12) month period.

3. Exclusions

    a. Nutritional counseling, tobacco counseling, and oral hygiene instructions provided by a Dentist.

III. **Basic Restorative Services**

A. **Fillings and Stainless Steel Crowns**

1. Covered

    a. Amalgam restorations (silver fillings), resin composite restorations (tooth-colored fillings), resin infiltrations, stainless steel crowns.

2. Limitations

    a. No more than one amalgam or resin restoration per tooth surface in any twelve (12) month period.

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

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

    d. No more than one (1) sealant, preventive resin restoration, or resin infiltration per first or second molar tooth per thirty-six (36) months. (Sealant/Preventive resins are subject to additional limitations listed under Preventive Services, and may be subject to a different Coverage level under "Attachment C: Schedule of Benefits.")

3. Exclusions

    a. Gold foil restorations.

B. **Other Basic Restorative Services**

1. Covered

    a. Repair of full and partial dentures and bridges.

    b. Crown and inlay re-cementation.

    c. Denture services including adjustments, relining, rebasing and tissue conditioning.

    d. General anesthesia and IV sedation only when administered by a properly licensed Dentist in a dental office in conjunction with Covered Surgery procedures or when necessary due to concurrent medical conditions.

2. Limitations

    a. No more than one (1) repair per denture per twenty-four (24) months.

b. Denture adjustments are Covered separately from the denture only after six (6) months from the date of initial placement.

c. No more than one (1) denture reline or rebase in any thirty-six (36) month period.

IV. **Major Restorative and Prosthodontic Services**

A. **Single Tooth Restorations**

1. Covered

a. Crowns (resin, porcelain, ¾ cast, and full cast), inlays and onlays (metallic, resin and porcelain), and veneers.

2. Limitations

a. Only for the treatment of severe carious lesions or severe fracture on permanent teeth, and only when teeth cannot be adequately restored with an amalgam or resin composite restoration (filling).

b. For permanent teeth only.

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

3. Exclusions

a. Temporary and provisional crowns.

B. **Multiple Tooth Restorations – Bridges**

1. Covered

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

2. Limitations

a. Only for treatment where a missing tooth or teeth cannot be adequately restored with a removable partial denture.

b. For permanent teeth only.

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

3. Exclusions

a. Interim pontic and retainer crowns.

C. **Removable Prosthodontics (Dentures)**

1. Covered

a. Complete, immediate and partial dentures.

2. Limitations

a. If, in the construction of a denture, the Member and the Dentist decide on a personalized restoration or to employ special rather than standard techniques or

materials, benefits provided shall be limited to those which would otherwise be provided for the standard procedures or materials (as determined by the Plan).

b. For permanent teeth only.

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

3. Exclusions

a. Interim (temporary) dentures.

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

1. Covered

a. Crown and bridge services including core build-ups, post and core, and repair.

b. Implants and implant-supported prosthetics, including local anesthetic.

c. Occlusal guards by report for extreme bruxism (grinding) and other occlusal factors.

2. Limitations

a. The benefits provided for crown and bridge restorations include benefits for the services of crown preparation, temporary or prefabricated crowns, impressions and cementation.

b. Benefits will not be provided for a core build-up separate from those provided for crown construction, except in those circumstances where benefits are provided for a crown because of severe carious lesions or fracture is so extensive that retention of the crown would not be possible.

c. Post and core services are Covered only when performed in conjunction with a Covered crown or bridge.

d. Crown, inlay, onlay, and veneer repair are Covered separately only after twelve (12) months from the date of initial placement.

e. Implant limited to one (1) per tooth per sixty (60) months.

f. Bone graft for implant is Covered if implant is Covered.

g. Implant debridement is limited to one (1) per tooth per sixty (60) months and is Covered, if implant is Covered.

h. Replacement of implant-supported prosthesis is Covered only after sixty (60) months from the date of any prosthesis placement.

i. Occlusal guards are limited to one (1) every twelve (12) months for Members age thirteen (13) to nineteen (19) by report for extreme bruxism.

3. Exclusions

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

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

c. Temporary and interim implant abutment.

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

A. **Basic Endodontics**

1. Covered

   a. Pulpotomy, pulpal therapy.

2. Limitations

   a. For primary teeth only.

   b. Not Covered when performed in conjunction with major endodontic treatment.

   c. The benefits for basic endodontic treatment include benefits for x-rays, pulp vitality tests, and protective restoration provided in conjunction with basic endodontic treatment. However, pulp vitality tests and protective restorations are not Covered when billed separately from other endodontic services.

3. Exclusions

   a. Pulpal debridement.

B. **Major Endodontics**

1. Covered Services

   a. Root canal treatment and re-treatment, apexification, pulpal regeneration, apicoectomy services, root amputation, retrograde filling, hemisection, pulp cap.

2. Limitations

   a. The benefits for major endodontic treatment include benefits for x-rays, pulp vitality tests, pulpotomy, pulpectomy and protective restoration and temporary filling material provided in conjunction with major endodontic treatment. However, pulp vitality tests and protective restorations are not Covered when billed separately from other endodontic services.

3. Exclusions

   a. Implantation, canal preparation, and incomplete endodontic therapy.

VI. **Periodontics**

A. **Basic Periodontics**

1. Covered

   a. Non-surgical periodontics, including periodontal scaling and root planing, full mouth debridement and periodontal maintenance procedure.

2. Limitations

   a. No more than one (1) periodontal scaling and root planing per quadrant in any twenty-four (24) month period.

   b. No more than one (1) full mouth debridement per lifetime.

   c. No more than four (4) of any prophylaxis (cleanings) or periodontal maintenance procedure in any twelve (12) month period. Cleanings are subject to additional

limitations listed under Preventive Services, and may be subject to a different Coverage level under "Attachment C: Schedule of Benefits."

d. Benefits for periodontal maintenance are provided only after active periodontal treatment (surgical or non-surgical), and no sooner than ninety (90) days after completion of such treatment.

e. Benefits for periodontal scaling and root planing, full mouth debridement, periodontal maintenance and prophylaxis are not provided when more than one (1) of these procedures is performed on the same day.

3. Exclusions

a. Provisional splinting, scaling in the presence of gingival inflammation, antimicrobial medication and dressing changes.

B. **Major Periodontics**

1. Covered

a. Surgical periodontics including gingivectomy, gingivoplasty, gingival flap procedure, crown lengthening, osseous Surgery and bone and tissue grafting.

b. Benefits provided for major periodontics include benefits for services related to ninety (90) days of postoperative care.

2. Limitations

a. No more than one (1) major periodontal Surgical Procedure in any thirty-six (36) month period.

3. Exclusions

a. Tissue regeneration and apically positioned flap procedure.

VII. **Oral Surgery**

A. **Basic Oral Surgery**

1. Covered

a. Non-surgical or simple extractions.

2. Limitations

a. Benefits provided for basic oral Surgery include benefits for suturing and postoperative care.

3. Exclusions

a. Benefits for general anesthesia or intravenous sedation when performed in conjunction with basic oral Surgery.

B. **Major Oral Surgery**

1. Covered

a. Surgical extractions (including removal of impacted teeth), coronectomy, and other oral Surgical Procedures typically not Covered under a medical plan.

b. Benefits provided for major oral Surgery include benefits for local anesthesia, suturing and postoperative care.

2. Limitations

a. Benefits for general anesthesia or intravenous (IV) sedation are provided only in connection with major oral Surgery procedures, and only when provided by a Dentist licensed to administer such agents.

3. Exclusion

a. Oral Surgery typically Covered under a medical plan including, but not limited to, excision of lesions and bone tissue, treatment of fractures, suturing, wound and other repair procedures and related procedures.

b. Harvesting of bone for use in autogenous grafting.

VIII. **General Pediatric Dental Exclusions**

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

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

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

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

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

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

F. Charges for any hospital or other surgical or treatment facility and any additional fees charged by a Dentist for treatment in any such facility.

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

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

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

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

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

L. Diagnostic dental services such as diagnostic tests and oral pathology services.

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

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

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

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

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

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

1. Covered Services

   a. Diagnosis and management 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 and exam; (2) office visit; (3) x-rays; (4) diagnostic study casts; (5) medications; and (6) Oral 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.

G. **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. See the “Pharmacy Prescription Drug Program” section for additional diabetic benefits.

1. Covered Services

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

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

2. Exclusions

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

b. Items not identified in the Mandated Diabetes Supply List.

H. **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 medicine and similar technologies.

   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.

I. **Durable Medical Equipment (DME)**

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 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 or obsolescence and aging. Insulin pump replacement is Covered only for pumps older than forty-eight (48) months and only if the pump cannot be repaired.

2. Exclusions

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

   b. Unnecessary repair, adjustment or replacement or duplicates of any such equipment.

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

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

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

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

g. "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 the Utilization Management department.

j. Portable ramp for a wheelchair.

J. **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 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.

An observation stay that occurs in conjunction with an ER visit will be subject to Member cost share under the "Outpatient Facility Services" section of "Attachment C: Schedule of Benefits," in addition to Member cost share for the ER visit.

2. Exclusions

a. Treatment of a chronic, non-Emergency condition, where the symptoms have existed over a period of time, and a prudent layperson who possesses an average knowledge of health and medicine would not believe it to be an Emergency.

b. Services received for inpatient care or transfer to another facility once Your medical condition has stabilized, unless Prior Authorization is obtained from the Plan within twenty-four (24) hours or the next working day.

K. **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 (1) family planning; (2) history; (3) physical examination; (4) diagnostic testing; and (5) genetic testing.

b. Sterilization procedures.

c. Services or supplies for the evaluation of infertility.

d. Medically Necessary and Appropriate termination of a pregnancy.

e. Injectable and implantable hormonal contraceptives and vaginal barrier methods including initial fitting, insertion and removal.

f. Abortions in the case of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed (i.e., abortions for which federal funding is allowed).

2. Exclusions

a. Services or supplies that are designed to create a pregnancy, enhance fertility or improve conception quality including, but not limited to, (1) artificial insemination; (2) in vitro fertilization; (3) fallopian tube reconstruction; (4) uterine reconstruction; (5) assisted reproductive technology (ART) including, but not limited to, gamete and zygote intrafallopian transfer (GIFT and ZIFT); (6) fertility injections; (7) fertility drugs; and (8) services for follow-up care related to infertility treatments.

b. Services or supplies for the reversals of sterilizations.

c. We do not provide benefits for procedures, equipment, services, supplies or charges for abortions for which Federal funding is prohibited. Federal funding is allowed for abortions, where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed.

L. **Home Health Care Services**

Medically Necessary and Appropriate services and supplies 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/Habilitative Services" section.

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 for (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.

M. **Hospice**

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

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

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; and (7) funeral or financial counseling.

N. **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 a disease and injury; and (4) has a staff of physicians licensed to practice medicine and provides twenty-four (24) hour nursing care by graduate registered nurses. Psychiatric hospitals are not required to have a surgical facility.

Prior Authorization for Covered Services must be obtained from the Plan, or benefits will be reduced or denied.

1. Covered Services

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

    b. Attending Practitioner's services for professional care.

    c. Maternity and delivery services (including routine nursery care and Complications of Pregnancy). If the hospital or physician provides services to the baby and submits a claim in the baby's name, benefits may be Covered for the baby and mother as separate Members, requiring payment of applicable Member Copayments and/or Deductibles.

2. Exclusions

    a. Inpatient stays primarily for therapy (such as physical or occupational therapy).

    b. Private duty nursing.

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

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

O. **Organ Transplants**

As soon as Your Practitioner tells You that You might need a transplant, You or Your Practitioner must contact the Plan's Transplant Case Management department. Call Our consumer advisors at the number on the back of Your Member ID card, and ask to be transferred to the Transplant Case Management department. A benefit specialist will explain Your transplant benefits including:

1. The Transplant Network Institutions available to You so You receive the highest level of benefits;
2. Your potential cost if an available Transplant Network Institution is not used; and
3. How to use Your travel benefit, if applicable.

Transplant case management is a mandatory program for those Members seeking Transplant Services.

1. Prior Authorization

   Transplant Services require Prior Authorization. Transplant Services or supplies that have not received Prior Authorization will not be Covered. "Prior Authorization" is the pre-treatment approval that must be obtained from Us before any pre-transplant evaluation or any Covered procedure is performed.

   You or Your Practitioner must contact the Plan's Transplant Case Management department before pre-transplant evaluation or Transplant Services are received.

2. Benefits

   (See section 6 below for kidney transplant benefit information.)

   Transplant benefits are different than benefits for other services. To avoid extra cost, which could be substantial, You must contact the Transplant Case Management department to be directed to the appropriate Transplant Network Provider.

   If a Transplant Network Institution is not used, benefits may be subject to reduced levels as outlined in "Attachment C: Schedule of Benefits." All solid organ and stem cell/bone marrow transplants must meet medical criteria and must be Medically Necessary and Medically Appropriate for the medical condition for which the transplant is recommended.

   You have access to three levels of benefits:

   a. Transplant Network transplants. If You go to a Transplant Network Provider, You will receive the highest level of benefits for Covered Services. The Plan will reimburse the Transplant Network Provider at the benefit level listed in "Attachment C: Schedule of Benefits." The Transplant Network Provider cannot bill You for any amount over Your Deductible and Out-of-Pocket Maximum, which limits Your liability. **Not all Network Providers are in Our Transplant Network. Please check with the Transplant Case Management department to see which hospitals are in Our Transplant Network.**

   b. Network transplants. If 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 level listed in "Attachment C: Schedule of Benefits," limited to a 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.**

c. Out-of-network transplants. If You have the transplant performed at a facility that is not a Network Provider or a BlueCard PPO Participating Provider, the Plan will reimburse the Out-of-Network Provider 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 the Transplant Case Management department. Remember, the Transplant Maximum Allowable Charge can and does change from time to time.

3. Covered Services

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

a. Kidney.

b. Kidney/Pancreas.

c. Pancreas.

d. Liver.

e. Heart.

f. Heart/Lung.

g. Lung.

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

i. Small bowel.

j. Multi-organ transplants as deemed Medically Necessary.

Benefits may be available for other organ transplant procedures that, in Our discretion, are not experimental or Investigational and that are Medically Necessary and Medically Appropriate.

4. Organ and Tissue Procurement

If a Covered person requires a solid organ or bone marrow/stem cell transplant, the cost of organ and tissue acquisition/procurement is included as part of the Covered person's Covered expenses. The cost of donor organ procurement is included in the total cost of Your organ transplant.

If the donor is not a Member, Covered Services for the donor are limited to the services and supplies directly related to the Transplant Service itself:

a. Donor search.

b. Testing for donor's compatibility.

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

d. Preservation of the organ/tissue.

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

f. Donor follow-up care.

Donor services are Covered only to the extent not covered by other health coverage. The Plan will Cover donor services for initial acquisition/procurement only. Complications, side effects or injuries are not Covered unless the donor is a Covered person on the Plan.

5. Travel Expenses

Travel expenses are Covered only if You go to a Transplant Network Institution.

Travel expenses are available to a Covered person who receives solid organ or stem cell Transplant Services at a Transplant Network Institution and:

a. An adult to accompany the Covered person; or

b. One or two parents of the Covered person (if the Covered person is a dependent child, as defined in this Policy).

Covered travel and lodging expenses must be approved by the Transplant Case Management department and include the following:

a. To and from the Transplant Network Institution for initial transplant evaluation, including services performed as part of the transplant episode of care prior to the Covered procedure.

b. To and from the Transplant Network Institution as required by the institution to remain listed for an approved transplant procedure.

c. To and from the Transplant Network Institution for a Covered transplant procedure and required post-transplant follow-up.

d. Transportation includes:

   i. Mileage for Your private car limited to reimbursement at the IRS mileage rate in effect at time of travel.

   ii. Airfare, approved by the Transplant Case Management department, reimbursed at coach rates.

   iii. Public transportation.

   iv. Parking fees.

   v. Tolls.

e. Lodging at or near the transplant facility including:

   i. Apartment rental.

   ii. Hotel rental.

   Lodging for purposes of this Plan does not include private residences.

f. In order to be reimbursed, travel must be approved by the Transplant Case Management department. In many cases, travel will not be approved for kidney transplants.

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

h. Approved travel expenses will be limited as stated below:

   i. Meals and lodging expenses, limited to $150 per day.

   ii. The aggregate limit for travel expenses is $10,000 per Covered procedure.

i. Travel benefits shall be payable for up to twelve (12) months from the date of the transplant while the Covered person is receiving required follow-up at the Transplant Network Institution subject to the aggregate limit stated above.

6. Kidney Transplants

Prior Authorization for Covered Services must be obtained from the Plan, or benefits will be reduced or denied.

There are two levels of benefits for kidney transplants: network and out-of-network:

a. Network kidney transplants. If 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.

b. Out-of-network kidney transplants. If 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.**

7. Exclusions

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

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

b. Any 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 would be covered by 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 not determined to be Medically Necessary.

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. 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.

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

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.

P. **Outpatient Facility Services**

Medically Necessary and Appropriate diagnostics, therapies and Surgery occurring in an outpatient facility that includes (1) outpatient Surgery centers; (2) the outpatient center of a hospital; (3) outpatient diagnostic centers; and (4) certain surgical suites in a Practitioner's office. Prior Authorization as required for certain outpatient services must be obtained from the Plan, 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 twenty-four (24) hours.
    f. Telehealth.
2. Exclusions
    a. Rehabilitative therapies in excess of the terms of the "Therapeutic/ Rehabilitative/Habilitative Services" section.
    b. Services that could be provided in a less-intensive setting.

Q. **Pharmacy Prescription Drug Program for Retail and Mail Order Prescriptions**

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

1. Covered Services
    a. This Policy covers the following at 100%, in accordance with the Women's Preventive Services provision of the Affordable Care Act:
        i. Generic contraceptives;
        ii. Vaginal ring;
        iii. Hormonal patch; and
        iv. Emergency contraception available with a Prescription.
        v. Brand name Prescription Contraceptive Drugs are Covered as any other Prescription, if a Generic Drug equivalent is available. See "Attachment C: Schedule of Benefits."
    b. Prescription Drugs and items listed in the Mandated Diabetes Supply List.
    c. Prescription Drugs must be:
        i. Prescribed on or after Your Coverage begins;
        ii. Approved for use by the Food and Drug Administration (FDA);
        iii. Dispensed by a licensed pharmacist or network physician;

iv. Listed on the Essential Drug Formulary.

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

e. Medically Necessary Prescription Drugs used during the induction or stabilization/dose-reduction phases of chemical dependency treatment.

f. Drugs with a Prescription that are listed with an A or B recommendation by the United States Preventive Services Task Force (USPSTF).

g. Immunizations administered at a Network Pharmacy.

2. Limitations

a. Refills must be dispensed pursuant to a Prescription. If the number of refills is not specified in the Prescription, benefits for refills will not be provided beyond one (1) year from the date of the original Prescription, unless otherwise specified by state or federal law.

b. The Plan has time limits on how soon a Prescription can be refilled. If You request a refill too soon, the Network Pharmacy will advise You when Your Prescription benefit will Cover the refill.

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

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

e. Injectable drugs are Covered only when (1) intended for self-administration; or (2) defined by the Plan.

f. Compound Drugs are only Covered when filled or refilled at a Network Pharmacy. The Network Pharmacy must submit the claim through the Plan's Pharmacy benefit manager. The claim must contain a valid national drug code (NDC) number for all ingredients in the Compound Drug. The Compound Drug claim will apply the Non-Preferred Brand Drug Copayment/Coinsurance. Prior Authorization may be required for certain compound medications.

g. Prescription Drugs that are commercially packaged or commonly dispensed in quantities less than a thirty (30) calendar day supply (e.g. Prescription items that are dispensed based on a certain quantity for a therapeutic regimen) will be subject to one drug Copayment, provided the quantity does not exceed the FDA-approved dosage for four (4) calendar weeks.

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

3. Exclusions

In addition to the limitations and exclusions specified in “Attachment A: Covered Services and Exclusions” and “Attachment B: Other Exclusions,” benefits are not available under this section for the following:

a. Drugs that are prescribed, dispensed or intended for use while You are confined in a hospital, skilled nursing facility or similar facility, except as otherwise Covered in the Policy;

b. Any drugs, medications, Prescription devices, dietary supplements or vitamins available over-the-counter that do not require a Prescription by federal or state law; and/or Prescription Drugs dispensed in a doctor’s office, except as otherwise Covered in the Policy;

c. Any Prescription Drug purchased outside the United States, except those Authorized by Us;

d. Any Prescription dispensed by or through a non-retail internet Pharmacy;

e. Contraceptives that require administration or insertion by a Provider (e.g., non-drug devices, implantable products), except as otherwise Covered in this Policy;

f. Medications intended to terminate a pregnancy;

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

h. Artificial appliances;

i. Allergen extracts;

j. Prescription Drugs You are entitled to receive without charge in accordance with any workers’ compensation laws or any municipal, state, or federal program;

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

l. Drugs dispensed by a Provider other than a Pharmacy or dispensing physician;

m. Administration or injection of any drugs;

n. Prescription Drugs used for the treatment of infertility;

o. Prescription Drugs not on the Essential Drug Formulary;

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

q. All newly FDA-approved drugs prior to review by the Plan’s P&T Committee. Prescription Drugs that represent an advance over available therapy according to the P&T Committee will be reviewed within at least six (6) months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug, will be reviewed within at least twelve (12) months after FDA approval;

r. Any Prescription Drugs or medications used for the treatment of sexual dysfunction including, but not limited to, erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido;

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

t. Prescription Drugs used during the maintenance phase of chemical dependency treatment, unless Authorized by Us;

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

v. Specialty Drugs filled or refilled at a Pharmacy not participating in the Specialty Pharmacy Network;

w. Drugs used to enhance athletic performance;

x. Experimental and/or Investigational Drugs;

y. Prescription Drugs that are illegal under federal law such as marijuana;

z. Prescription and over-the-counter (OTC) nicotine replacement therapy and aids to smoking cessation including, but not limited to, patches, except as required by the Affordable Care Act.

4. Pharmacy Exception Requests

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

    a. Will be or have been ineffective;

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

    c. Would have adverse effects.

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

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

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

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

As part of the expedited review request, the prescribing Practitioner should include:

a. An oral or written statement that an exigent circumstance exists and explain the harm that could reasonably be expected to the Member if the requested Prescription Drug is not provided within the timeframes of the standard exception request process (outlined above in subsection a); and

b. An oral or written justification supporting the need for the Prescription Drug not included in Our Essential Drug Formulary to treat the Member's condition, including a statement that:

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

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

3. Would have adverse effects.

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

a. Without unreasonable delay; and

b. For the duration of the exigent circumstance.

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

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

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

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

GENERIC DRUGS

Prescription Drugs are classified as brand or generic. A given drug can change from brand to generic or from generic to brand. Sometimes a given drug is no longer available as a Generic Drug. These changes can occur without notice. If You have any questions, please contact Our consumer advisors by calling the number of the back of Your Member ID card.

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

The Essential Drug Formulary referenced in this section is subject to change. Current lists can be found at bcbst.com, or by calling the number on the back of Your Member ID card.

R. **Pharmacy Prescription Drug Program for Self-Administered Specialty Drugs**

Medically Necessary and Appropriate Specialty Drugs monitored by a Practitioner or home health care agency for the treatment of disease and listed as a self-administered drug on the Plan's Specialty Drug list. Certain Specialty Drugs require Prior Authorization from the Plan, or benefits will be reduced or denied. Call Our consumer advisors at the number on the back of Your Member ID card or visit bcbst.com to find out which Specialty Drugs require Prior Authorization. Refer to the "Provider-Administered Specialty Drugs" section for Provider-administered Specialty Drugs benefit coverage information.

1. Covered Services

    a. Self-administered Specialty Drugs. Only those drugs listed as self-administered Specialty Drugs are Covered under this benefit.

2. Exclusions

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

Specialty Drugs. You have a distinct network for Specialty Drugs: the Specialty Pharmacy Network. To receive benefits for self-administered Specialty Drugs, You must use a Specialty Pharmacy Network Provider.

S. **Practitioner Office Services**

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

1. Covered Services

    a. Diagnosis and treatment of illness or injury. Note that allergy skin testing is Covered only in the Practitioner office setting. Medically Necessary RAST (radioallergosorbent test), FAST (fluorescent allergosorbent test), or MAST (multiple radioallergosorbent test) is Covered in the Practitioner office setting and in a licensed laboratory.

    b. Injections and medications administered in a Practitioner's office, except Specialty Drugs. (See the "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 Surgery.

    d. Preventive/Well care services.

        i. Preventive Health Exam and related services for adults and children as outlined below and performed by the physician during the Preventive Health Exam or referred by the physician as appropriate, including:

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

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

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

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

e. Telehealth.

f. 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; and (6) marriage or legal proceedings.

b. 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.

c. Rehabilitative therapies in excess of the limitations of the "Therapeutic/ Rehabilitative/Habilitative Services" section.

d. Dental procedures, except as otherwise indicated in this Policy.

T. **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 incidental to a Practitioner's services or on a Practitioner's order.

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

e. The initial purchase of artificial limbs or eyes.

f. The first set of eyeglasses or contact lenses required to adjust for vision changes due to cataract Surgery and obtained within six (6) months following the Surgery.

g. Hearing aids, limited as indicated in "Attachment C: Schedule of Benefits."

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.

U. **Provider-Administered Specialty Drugs**

Medically Necessary and Appropriate Specialty Drugs administered by a Practitioner or home health care agency for the treatment of disease and listed as a Provider-administered drug on the Plan's Specialty Drug list. Certain Specialty Drugs require Prior Authorization from the Plan, or benefits will be reduced or denied. Call Our consumer advisors at the number on the back of Your Member ID card or visit bcbst.com to find out which Specialty Drugs require Prior Authorization. Refer to the "Pharmacy Prescription Drug Program for Self-Administered Specialty Drugs" section for self-administered Specialty Drugs benefit Coverage information.

1. Covered Services

    a. Provider-administered Specialty Drugs, including administration by a qualified Provider. Only those drugs listed as Provider-administered Specialty Drugs are Covered under this benefit.

2. Exclusions

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

V. **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 or partial mastectomy (other than lumpectomy) including Surgery on the non-diseased breast needed to establish symmetry between the two breasts.

2. Exclusions

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

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

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

W. **Skilled Nursing/Rehabilitative Facility Services**

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

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

X. **Supplies**

Those 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.

    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.

Y. **Therapeutic/Rehabilitative/Habilitative Services**

Medically Necessary and Appropriate therapeutic, rehabilitative, and habilitative services performed in a Practitioner's office, outpatient facility or home health setting and intended to enable a person with a disability to attain functional abilities, or to restore or improve bodily function lost as the result of illness, injury, autism, or cleft palate.

1. Covered Services
    a. Outpatient, home health or office therapeutic, rehabilitative and habilitative services. The services must be performed by, or under the direct supervision of a licensed therapist.
    b. Therapeutic/Rehabilitative/Habilitative services include (1) physical therapy; (2) speech therapy for restoration of speech; (3) occupational therapy; (4) spinal manipulation therapy; and (5) cardiac and pulmonary rehabilitative services.
    c. Coverage is limited, as indicated in "Attachment C: Schedule of Benefits."

i. The limit on the number of visits for therapy applies to all visits for that therapy, whether received in a Practitioner's office, outpatient facility or home health setting.

ii. Services received during an inpatient hospital, skilled nursing or rehabilitative facility stay are Covered as shown in the "Inpatient Hospital Services" and "Skilled Nursing/Rehabilitative Facility Services" sections, and are not subject to the therapy visit limits.

2. Exclusions

a. Enhancement therapy that is designed to improve Your physical status beyond Your pre-injury or pre-illness state.

b. Complementary and alternative therapeutic services including, but not limited to, (1) massage therapy; (2) 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.

c. Modalities that do not require the attendance or supervision of a licensed therapist. These include, but are not limited to, (1) activities that are primarily social or recreational in nature; (2) simple exercise programs; (3) hot and cold packs applied in the absence of associated therapy modalities; (4) repetitive exercises or tasks that You can perform without a therapist, in a home setting; (5) routine dressing changes; and (6) custodial services that can ordinarily be taught to You or a caregiver.

d. 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.

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

Z. **Vision – Medically Necessary for all Members**

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. The first set of eyeglasses or contact lenses required to adjust for vision changes due to cataract Surgery and obtained within six (6) months following the Surgery.

2. Exclusions

a. Routine vision services, including services, Surgeries and supplies to detect or correct refractive errors of the eyes.

b. Eyeglasses, contact lenses and examinations for the fitting of eyeglasses and contact lenses.

c. Eye exercises and/or therapy.

d. Visual training.

AA. **Vision – Pediatric Vision**

This "Vision - Pediatric Vision" section provides a wide range of benefits to Cover services associated with vision care for dependents under age nineteen (19). Plan benefits are based on the services and supplies described in this "Attachment A: Covered Services and Exclusions" and provided in accordance with the benefit schedules set forth in this Policy's "Attachment C: Schedule of Benefits."

Medically Necessary and Appropriate routine vision care services.

A. Covered Services

a. Routine vision services, including services and supplies to detect or correct refractive errors of the eyes.

B. Limitations

a. Vision Examinations are Covered once every Calendar Year.

b. Eyeglass frames are Covered once every Calendar Year.

c. Eyeglass lenses or contact lenses are Covered once every Calendar Year.

d. Prescription sunglasses will be handled as any other lens.

e. Benefits are not available more frequently than as specified in "Attachment C: Schedule of Benefits."

f. Discounts do not apply for benefits provided by other group benefit plans or promotional offers.

C. Exclusions

a. Medical and/or surgical treatment of the eye, eyes, or supporting structure, including Surgeries to detect or correct refractive errors of the eyes.

b. Eye exercises and/or therapy.

c. Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; aniseikonic lenses.

d. Charges for lenses and frames ordered while insured but not delivered within sixty (60) days after Coverage is terminated, or for vision testing examinations that occur after the date of termination.

e. Charges for non-Prescription sunglasses, photosensitive, anti-reflective or other optional charges when the charge exceeds the amount allowable for regular lenses.

f. Charges filed for procedures determined by the Plan to be special or unusual (i.e. orthoptics, vision training, subnormal vision aids, aniseikonic lenses, tonography, corneal refractive therapy, etc.).

g. Charges for lenses that do not meet the Z80.1 or Z80.2 standards of the American National Standards Institute.

h. Charges in excess of the Covered benefit as established by the Plan.

i. Oversized Lenses.

j. Corrected eyewear required by an employer as a condition of employment, and safety eyewear unless specifically Covered under the Plan.

k. Non-Prescription lenses and frames, and non-Prescription sunglasses.

l. Services or materials provided by any other group benefit providing vision care.

m. Two (2) pairs of glasses in lieu of bifocals.

n. Charges for replacement of broken, lost, or stolen lenses, contact lenses, or frames.

o. Charges for services or materials from an Ophthalmologist, Optometrist or Optician acting outside the scope of his or her license.

p. Charges for any additional service required outside basic vision analyses for contact lenses, except fitting fees.

Attachment B: Other Exclusions

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

1. Services or supplies not listed as Covered Services under "Attachment A: Covered Services and Exclusions";
2. Services or supplies that are not determined to be 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. Services or supplies provided by a Provider that is not accredited or licensed or are outside the scope of his/her/its license.
5. Illness or injury resulting from war, that occurred before Your Coverage began under this Policy and that is Covered by (1) veteran's benefit; or (2) other coverage for which You are legally entitled;
6. Self-treatment or training;
7. Staff consultations required by hospital or other facility rules;
8. Services rendered free of charge, except when rendered by a non-governmental, charitable research hospital that bills patients for services rendered but does not enforce collection from an individual patient;
9. Services or supplies for the treatment of work-related illness or injury, regardless of the presence or absence of workers' compensation coverage. This exclusion does not apply to injuries or illnesses of an employee who is (1) a sole-proprietor of the group, unless required by law to carry workers' compensation insurance; (2) a partner of the group, unless required by law to carry workers' compensation insurance; or (3) a corporate officer of the group, provided the officer filed an election not to accept workers' compensation with the appropriate government department;
10. Personal, physical fitness, recreational or convenience items and services, even if ordered by a licensed Practitioner, including but not limited to, weight loss programs and equipment; physical fitness/exercise programs and equipment; devices and computers to assist in communication or speech (e.g., Dynabox); air conditioners, humidifiers, air filters and heaters; saunas, swimming pools and whirlpools; water purifiers; tanning beds; televisions; barber and beauty services;
11. Services or supplies received before Your Effective Date for Coverage with this Plan;
12. Services or supplies related to a Hospital Confinement, received before Your Effective Date for Coverage with this Plan;
13. Services or supplies received after Your Coverage under this Plan ceases for any reason. This is true even though the expenses relate to a condition that began while You were Covered.
14. Services or supplies received in a dental or medical department maintained by or on behalf of the employer, mutual benefit association, labor union or similar group;
15. Services or charges to complete a claim form or to provide medical records or other administrative functions. We will not charge You or Your legal representative for statutorily required copying charges;

16. Charges for failure to keep a scheduled appointment;
17. Charges for telephone consultations, email or web-based consultations, except as 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 Policy or in accordance with the Covered Services for Telehealth in the "Attachment A: Covered Services and Exclusions" section of this Policy;
18. Court ordered examinations and treatment, unless Medically Necessary;
19. Room, board and general nursing care rendered on the date of discharge, unless admission and discharge occur on the same day;
20. Charges in excess of the Maximum Allowable Charge for Covered Services;
21. Any service stated in the "Attachment A: Covered Services and Exclusions" as a non-Covered Service or limitation;
22. Charges for services performed by You or Your spouse, or Your or Your spouse's parent, sister, brother or child;
23. Any charges for handling fees;
24. Safety items, or items to affect performance primarily in sports-related activities;
25. 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;
26. 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;
27. Services considered Cosmetic, except when Medically 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. Services that could be considered Cosmetic include, but are not limited to, (1) keloid removal; (2) dermabrasion; (3) chemical peels; (4) breast augmentation; (5) lipectomy; (6) laser resurfacing; (7) sclerotherapy injections, laser or other treatment of spider veins and varicose veins; (8) rhinoplasty; (9) panniculectomy/abdominoplasty; (10) Botulinum toxin;
28. Services that are always considered Cosmetic including, but not limited to, (1) removal of tattoos; (2) facelifts; (3) body contouring or body modeling; (4) injections to smooth wrinkles; (5) piercing ears or other body parts; (6) rhytidectomy or rhytidoplasty (Surgery for the removal or elimination of wrinkles); (7) thighplasty; (8) brachioplasty;
29. Blepharoplasty and browplasty;
30. Charges relating to surrogate pregnancy when the surrogate mother is a Member and receives compensation including, but not limited to, maternity and delivery charges; and charges relating to surrogate pregnancy when the surrogate mother is not a Covered Member under this Plan;
31. Sperm preservation;

32. Services or supplies for orthognathic Surgery, a discipline to specifically treat malocclusion except as appropriate per medical policy and when performed in conjunction with orthodontia for Members under age nineteen (19). Orthognathic Surgery is not Surgery to treat cleft palate or TMJ/TMD.
33. Services or supplies for Maintenance Care;
34. Private duty nursing;
35. Unless Covered in the "Pharmacy Prescription Drug Program for Retail and Mail Order Prescriptions" section, services or supplies to treat sexual dysfunction, regardless of cause, including, but not limited to, erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido;
36. Charges for injuries due to chewing or biting or received in the course of other dental procedures;
37. Services or supplies related to complications of Cosmetic procedures, complications of bariatric Surgery; re-operation of bariatric Surgery or body remodeling after weight loss;
38. Cranial orthosis, including helmet or headband, for the treatment of non-synostotic plagiocephaly;
39. 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;
40. Vagus nerve stimulation for the treatment of depression;
41. Balloon sinuplasty for treatment of chronic sinusitis;
42. Treatment for benign gynecomastia;
43. Treatment for hyperhidrosis;
44. Intradiscal annuloplasty to treat discogenic back pain. This procedure provides controlled delivery of heat to the intervertebral disc through an electrode or coil;
45. Methadone not received at a pharmacy;
46. Human growth hormones, unless Covered in the "Pharmacy Prescription Drug Program for Retail and Mail Order Prescriptions" section;
47. Unless Covered in the "Pharmacy Prescription Drug Program for Retail and Mail Order Prescriptions" section, nicotine replacement therapy and aids to smoking cessation including, but not limited to, patches;
48. Prescription Drugs that are illegal under federal law such as marijuana.

Attachment D: Eligibility

If You are eligible for Coverage, You can enroll under this Policy upon payment of the required Premium for such Coverage. The Health Insurance Marketplace/Exchange will be responsible for making eligibility determinations for enrollment in Coverage through the Health Insurance Marketplace/Exchange, in accordance with the requirements specified under the Affordable Care Act (ACA). If there is a question about eligibility, the Health Insurance Marketplace/Exchange will make the final decision.

A. **Subscriber**

To be eligible to enroll as a Subscriber in this Plan through the Health Insurance Marketplace/Exchange, You must:

1. Be a resident of Tennessee, not residing outside the United States of America for more than six (6) months out of the year;
2. Not be Covered under any other individual or group health policy or plan of benefits;
3. Be a citizen of the United States of America or maintain a student visa, work visa and/or a valid green card;
4. Not be incarcerated, other than incarceration pending the disposition of charges;
5. Complete an Application, for You and any dependent You want to cover; and
6. Submit the completed and signed Application to the Health Insurance Marketplace/Exchange.

B. **Covered Dependents**

You can apply for Coverage for Your dependents, at the same time You apply for Coverage through the Health Insurance Marketplace/Exchange. Your dependents must be listed on Your Application, and be:

1. Your current spouse, as recognized under any state law; or
2. Your or Your spouse's (1) natural child; (2) legally adopted child (including children placed with You for the purposes of adoption); (3) step-child(ren); or (4) children for whom You or Your spouse are legal guardians, or for whom You have a Qualified Medical Child Support Order. The child(ren) must also be under age 26; or
3. Your or Your spouse's Incapacitated Child.

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Chattanooga, TN 37402

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ATTACHMENT C: SCHEDULE OF BENEFITS

Product Name: G11
Network: P

PLEASE READ THIS IMPORTANT STATEMENT: Network Benefits apply to services received from Network Providers and Non-Contracted Providers. **Out-of-network benefit percentages apply to BlueCross Maximum Allowable Charge, not to the Provider's Billed Charge. When using Out-of-Network Providers, the Member 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 Policy.

Preventive Care		
Covered Services	**Network Providers**	**Out-of-Network Providers**
Preventive/Well care services Includes: • Preventive Health Exam for adults or children • Well Woman Exam • Screenings, including screenings with an A or B recommendation by the United States Preventive Services Task Force (USPSTF), Bright Futures recommendations for infants, children and adolescents supported by the Health Resources and Services Administration (HRSA), and screenings for women as provided in the guidelines supported by HRSA. Examples include, but are not limited to, screenings for breast cancer, cervical cancer, prostate cancer, colorectal cancer, high cholesterol, and sexually transmitted infections. • Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Centers for Disease Control and Prevention (CDC). • Preventive counseling services with an A or B recommendation by the United States Preventive Services Task Force (USPSTF). Alcohol misuse and tobacco use counseling are limited to eight (8) visits per Calendar Year and must be provided in a primary care setting. Dietary counseling for adults with hyperlipidemia, hypertension, type 2 diabetes, coronary artery disease and congestive heart failure is limited to six (6) visits per Calendar Year.	100%	50% of the Maximum Allowable Charge after Deductible

Covered Services	Network Providers	Out-of-Network Providers
Lactation counseling by a trained Provider during pregnancy or in the postpartum period	100%	50% of the Maximum Allowable Charge after Deductible
Manual breast pump, limited to one (1) per pregnancy	100%	50% of the Maximum Allowable Charge after Deductible
FDA-approved contraceptive methods, sterilization procedures and counseling for women with reproductive capacity	100%	50% of the Maximum Allowable Charge after Deductible
Screening colonoscopy or screening flexible sigmoidoscopy For non-screening colonoscopy or sigmoidoscopy benefits, see **Office Surgery** under the **Practitioner Office Visits** section or **Outpatient Facility Services / Outpatient Surgery** section of this schedule	100%	50% of the Maximum Allowable Charge after Deductible
Practitioner Office Visits (Except for Preventive Care)		
Diagnosis and treatment of illness or injury, including medical and behavioral health conditions Primary care Practitioner types (Internal Medicine, General Practice, Family Medicine, Pediatrics, Obstetrics and Gynecology, Behavioral Health Services, Physician Assistant, Nurse Practitioner, Health Department) All other Practitioners The Copayment for a Physician Assistant or Nurse Practitioner may be based on the Provider type of the delegate physician.	100% after $35 Copayment 100% after $50 Copayment	50% of the Maximum Allowable Charge after Deductible

Covered Services	Network Providers	Out-of-Network Providers
Maternity care - initial office visit to confirm pregnancy Primary care Practitioner types (Internal Medicine, General Practice, Family Medicine, Pediatrics, Obstetrics and Gynecology, Behavioral Health Services, Physician Assistant, Nurse Practitioner, Health Department) All other Practitioners The Copayment for a Physician Assistant or Nurse Practitioner may be based on the Provider type of the delegate physician. The Copayment applies to the initial office visit to confirm pregnancy. For benefits for subsequent prenatal visits, postnatal visits and physician delivery charge, see Inpatient Hospital Stays in the Services Received at a Facility section. Benefits for specialty care, even if related to pregnancy, are considered as any other illness, and are not part of the global maternity fee.	100% after $35 Copayment 100% after $50 Copayment	50% of the Maximum Allowable Charge after Deductible
Allergy testing	100%	50% of the Maximum Allowable Charge after Deductible
Allergy injections and allergy extract	100%	50% of the Maximum Allowable Charge after Deductible
Provider-administered Specialty Drugs	$120 Copayment per Prescription	50% of the Maximum Allowable Charge after Deductible
All other medicine injections, excluding Specialty Drugs For Surgery injections, please see **Office Surgery** under the **Practitioner Office Visits** section of this schedule.	100%	50% of the Maximum Allowable Charge after Deductible

Covered Services	Network Providers	Out-of-Network Providers
Office Surgery, including anesthesia, performed in and billed by the Practitioner's office Surgeries include incisions, excisions, biopsies, injection treatments, fracture treatments, applications of casts and splints, sutures, and invasive diagnostic services (e.g., colonoscopy, sigmoidoscopy and endoscopy). Some procedures require Prior Authorization. Call Our consumer advisors to determine if Prior Authorization is required. See the "Prior Authorization, Care Management, Medical Policy and Patient Safety" section of this Policy for more information.	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
Non-routine treatments including renal dialysis, radiation therapy, chemotherapy and infusions Primary care Practitioner types (Internal Medicine, General Practice, Family Medicine, Pediatrics, Obstetrics and Gynecology, Behavioral Health Services, Physician Assistant, Nurse Practitioner, Health Department) All other Practitioners The Copayment for a Physician Assistant or Nurse Practitioner may be based on the Provider type of the delegate physician. Does not apply to Specialty Drugs. **See Provider-Administered Specialty Drugs** under the **Practitioner Office Visits** section of this schedule for applicable benefit.	100% after $35 Copayment 100% after $50 Copayment	50% of the Maximum Allowable Charge after Deductible
Supplies	100%	50% of the Maximum Allowable Charge after Deductible

Services Received at a Facility		
Prior Authorization is required for inpatient hospital stays (except maternity), inpatient Behavioral Health Services, skilled nursing facility or rehabilitation facility stays and for certain outpatient facility procedures. Call Our consumer advisors to determine if Prior Authorization is required before receiving inpatient and outpatient facility services. **See the "Prior Authorization, Care Management, Medical Policy and Patient Safety" section of this Policy for more information.**		
Inpatient Hospital Stays, Including Inpatient and Residential Care Behavioral Health Services and Maternity Stays		
Covered Services	**Network Providers**	**Out-of-Network Providers**
Facility charges	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
Practitioner charges, including global maternity delivery charges billed as inpatient services	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
Skilled Nursing or Rehabilitation Facility Stays Limited to sixty (60) days combined per Calendar Year		
Facility charges	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
Practitioner charges	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
Outpatient Facility Services, Including Behavioral Health Intensive Outpatient and Partial Hospitalization Programs **Outpatient Surgery** Surgeries include invasive diagnostic services (e.g., non-screening colonoscopy, sigmoidoscopy and endoscopy).		
Facility charges	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
Practitioner charges	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
Supplies	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
Provider-administered Specialty Drugs	100% after Deductible	50% of the Maximum Allowable Charge after Deductible

Covered Services	Network Providers	Out-of-Network Providers
All other services received at an outpatient facility, including chemotherapy, radiation therapy, renal dialysis and sleep studies	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
Hospital Emergency Care Services		
Emergency Room charges An observation stay that occurs in conjunction with an ER visit will be subject to Member cost share under the **Outpatient Facility Services** section of this schedule in addition to Member cost share for the ER visit.	100% after Deductible	100% of the Maximum Allowable Charge after Deductible
Advanced Radiological Imaging services Includes CT scans, MRIs, PET scans, nuclear medicine and similar technologies	100% after Deductible	100% of the Maximum Allowable Charge after Deductible
All other hospital charges	100% after Deductible	100% of the Maximum Allowable Charge after Deductible
Practitioner charges	100% after Deductible	100% of the Maximum Allowable Charge after Deductible
Other Services (Any Place of Service)		
Advanced Radiological Imaging services Includes CT scans, MRIs, PET scans, nuclear medicine and similar technologies **Advanced Radiological Imaging services require Prior Authorization, except when performed as part of an Emergency care visit**. See the "Prior Authorization, Care Management, Medical Policy and Patient Safety" section of this Policy for more information.	100% after Deductible	50% of the Maximum Allowable Charge after Deductible

Covered Services	Network Providers	Out-of-Network Providers
All other diagnostic services for illness, injury or maternity care	100%	50% of the Maximum Allowable Charge after Deductible
Therapy services Physical, speech, occupational, and spinal manipulation therapy limited to twenty (20) visits per therapy type per Calendar Year; cardiac and pulmonary rehab therapy limited to thirty-six (36) visits per therapy type per Calendar Year An office visit Copayment may apply to evaluation and management claims filed by a therapy Provider. Please refer to the **Practitioner Office Visits** section of this schedule.	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
Home health care services, including home infusion therapy Home health care is limited to sixty (60) visits per Calendar Year Prior Authorization is required for skilled nurse visits in the home, including those for home infusion therapy. Physical, speech, occupational or habilitative therapy provided in the home does not require Prior Authorization. See the "Prior Authorization, Care Management, Medical Policy and Patient Safety" section of this Policy for more information.	100% after Deductible	50% of the Maximum Allowable Charge after Deductible

Covered Services	Network Providers	Out-of-Network Providers
Durable medical equipment (DME), orthotics and prosthetics including DME supplies Prior Authorization may be required for certain DME, orthotics, or prosthetics. See the "Prior Authorization, Care Management, Medical Policy and Patient Safety" section of this Policy for more information.	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
Hearing aids, limited to one (1) per ear every three (3) years as determined by Your Calendar Year	100% after Deductible	50% of the Maximum Allowable Charge after Deductible
Ambulance	100% after Deductible	100% of the Maximum Allowable Charge after Deductible
Hospice care **Prior Authorization is required for inpatient stays.** See the "Prior Authorization, Care Management, Medical Policy and Patient Safety" section of this Policy for more information.	100%	50% of the Maximum Allowable Charge after Deductible

Organ Transplant Services			
Covered Services	**Transplant Network Providers**	**Network Providers not in Our Transplant Network**	**Out-of-Network Providers**
All organ Transplant Services, except kidney transplants 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 Our consumer advisors before any pre-transplant evaluation or other Transplant Service is performed to request Prior 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 Transplant Maximum Allowable Charge (TMAC) not Covered by the Plan. See the "Prior Authorization, Care Management, Medical Policy and Patient Safety" and "Organ Transplants" sections of this Policy for more information.	100% after network Deductible; network Out-of-Pocket Maximum applies.	100% 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. Network Providers not in our Transplant Network include Network Providers in Tennessee and BlueCard PPO Participating Providers outside Tennessee	50% of Maximum Allowable Charge (MAC), after out-of-network Deductible; out-of-network Out-of-Pocket Maximum applies. Amounts over MAC do not apply to the Out-of-Pocket Maximum and are not Covered.

Covered Services	Network Providers	Out-of-Network Providers
Kidney Transplant Services All organ transplants require Prior Authorization. Benefits will be denied without Prior Authorization. Call Our consumer advisors before any pre-transplant evaluation or other Transplant Service is performed to request Prior Authorization. See the "Prior Authorization, Care Management, Medical Policy and Patient Safety" and "Organ Transplants" sections of this Policy for more information.	100% after network Deductible; network Out-of-Pocket Maximum applies.	50% of Maximum Allowable Charge (MAC), after out-of-network Deductible; out-of-network Out-of-Pocket Maximum applies. Amounts over MAC do not apply to the Out-of-Pocket Maximum and are not Covered.

Pharmacy Prescription Drug Program for Retail and Mail Order Prescriptions			
Prescription Drugs [1,2] **Copay applies to each thirty (30) day supply**	**Generic Drug / Preferred Brand Drug / Non-Preferred Brand Drug[3]**	**Generic Drug / Preferred Brand Drug / Non-Preferred Brand Drug[3]**	**Generic Drug / Preferred Brand Drug / Non-Preferred Brand Drug[1]**
Retail network up to a thirty (30) day supply	$8/$35/$60	N/A	N/A
Mail Order Network and Select90 Network up to a ninety (90) day supply	$8/$35/$60	$16/$70/$120	$24/$105/$180
Out-of-network [3, 4]	50% of the Maximum Allowable Charge after Deductible		

Specialty Drugs - You have a distinct network for Specialty Drugs: the Specialty Pharmacy Network. To receive benefits for self-administered Specialty Drugs, You must use a Specialty Pharmacy Network Provider. For information on benefits for Provider-administered Specialty Drugs, please refer to the "Provider-Administered Specialty Drugs" section of this Policy.

Specialty Drugs are limited up to a thirty (30) day supply per Prescription.

Specialty Drugs [1,2]	**Specialty Pharmacy Network**
Self-administered Specialty Drugs, as indicated on Our Specialty Drug list.	$120 Copayment per Prescription
Out-of-network	Not Covered

Pediatric Dental		
Covered Services	**Network Dentists**	**Out-of-Network Dentists**
Coverage A: Diagnostic and preventive services: exams; cleanings; x-rays	100%	100% of the Maximum Allowable Charge
Coverage B: Basic and restorative services: basic restorative; basic endodontics; oral Surgery; basic periodontics	80%	80% of the Maximum Allowable Charge
Coverage C: Major restorative and prosthodontic services: major restorative; major endodontics; major periodontics implants	50%	50% of the Maximum Allowable Charge
Coverage D: Medically Necessary orthodontia Prior Authorization is required. See the "Prior Authorization, Care Management, Medical Policy and Patient Safety" section of this Policy for more information.	100% after Deductible	50% of the Maximum Allowable Charge after Deductible

Pediatric Vision		
Covered Services	**Network Providers**	**Out-of-Network Providers**
Exam with dilation as necessary	$0 Copayment	60% of Maximum Allowable Charge
Contact Lens Fit and Follow-Up: Contact lens fit and two (2) follow-up visits are available once a comprehensive eye exam has been completed.		
Standard contact lens fit and follow-up	$0 Copayment	60% of Maximum Allowable Charge
Premium contact lens fit and follow-up		
Frames: Provider-designated frames available at the Provider's location	100%	60% of Maximum Allowable Charge
Standard Lenses (Glass or Plastic):		
Single vision	$0 Copayment	60% of Maximum Allowable Charge
Bifocal		
Trifocal		
Lenticular		
Standard progressive lens		
Lens Options:		
UV treatment	$0 Copayment	60% of Maximum Allowable Charge
Tint (fashion & gradient & glass-grey)		
Standard plastic scratch Coating		
Standard polycarbonate		
Photocromatic / Transitions plastic		
Contact Lenses: Provider-designated contact lenses available at the Provider location Contact lens includes materials only		
Extended wear and extended wear disposables Up to six (6) month supply of monthly or two (2) week disposable, single vision spherical or toric contact lenses	100%	60% of Maximum Allowable Charge
Daily wear / disposables Up to three (3) month supply of daily disposable, single vision spherical contact lenses		

Deductible and Out-of-Pocket Maximum		
	Network	**Out-of-Network**
Deductible		
Individual	$3,500	$7,000
Family	$3,500 per Member, not to exceed $7,000 for all Covered Family Members	$7,000 per Member, not to exceed $14,000 for all Covered Family Members
Out-of-Pocket Maximum		
Individual	$3,500	$10,500
Family	$3,500 per Member, not to exceed $7,000 for all Covered Family Members	$10,500 per Member, not to exceed $21,000 for all Covered Family Members

1. If You or the prescribing physician choose a Preferred or Non-Preferred Brand Drug when a Generic Drug equivalent is available, You will be financially responsible for the amount by which the cost of the Preferred or Non-Preferred Brand Drug exceeds the Generic Drug cost plus the required Generic Drug Copayment.
2. Some products may be subject to Quantity Limits, Step Therapy, and Prior Authorizations specified by the Plan's P&T Committee.
3. If You have a Prescription filled at an Out-of-Network Pharmacy, You must pay all expenses and file a claim for reimbursement with Us. Reimbursement is based on the Maximum Allowable Charge, less any applicable out-of-network Deductible, Coinsurance, and/or Drug Copayment amount.
4. Compound Drugs are considered Non-Preferred Brand Drugs and only Covered when filled at a Network Pharmacy.