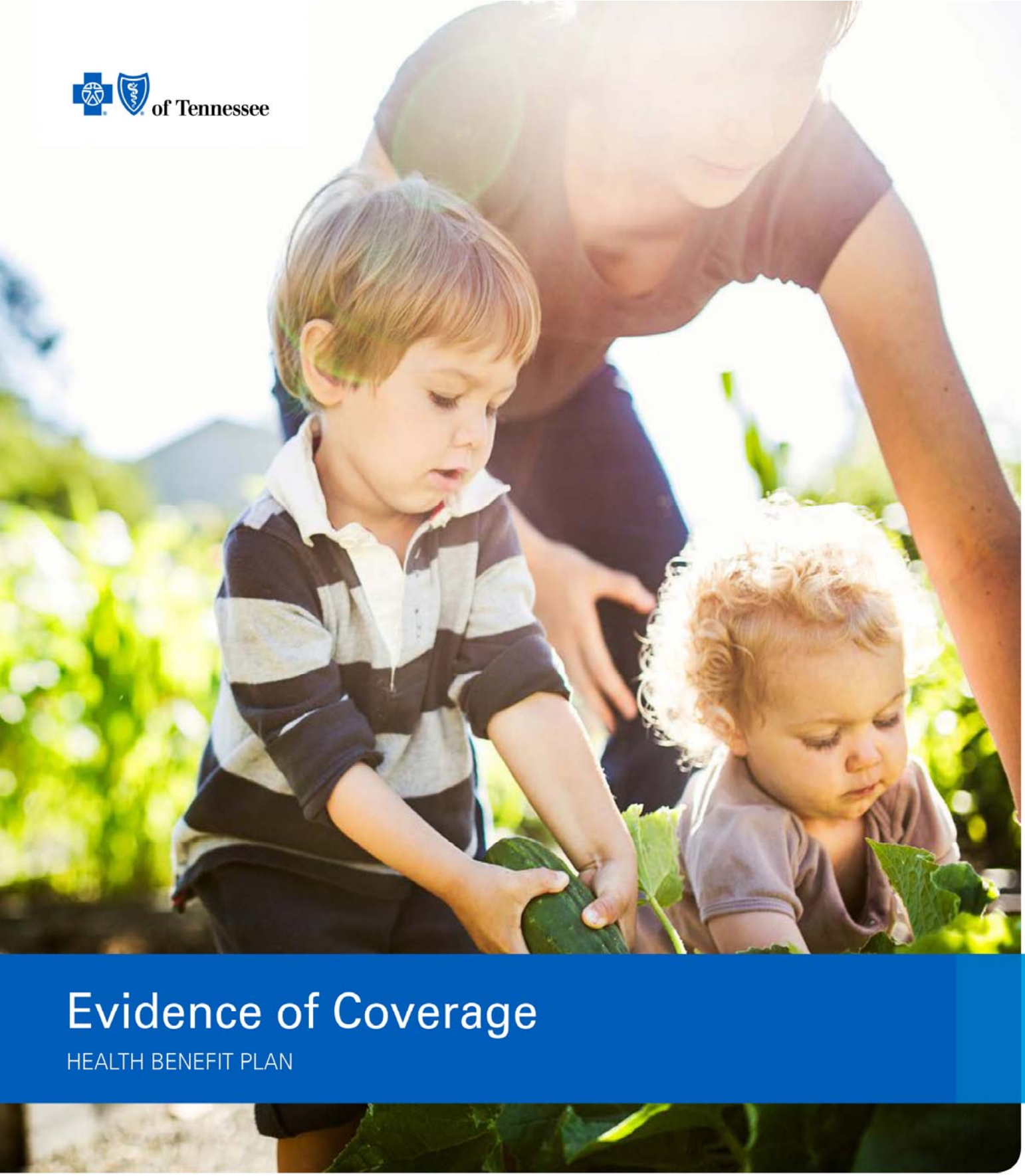

Oak Ridge Associated Universities-2019

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

NOTICE

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

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

Nondiscrimination Notice

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

BlueCross:

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

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

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

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

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

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

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

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

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

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

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-565-9140 (TTY: 1-800-848-0298).

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

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

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

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

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

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

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

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

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

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

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

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

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

TABLE OF CONTENTS

Introduction

This Evidence of Coverage (this "EOC") was created for ORAU as part of its Employee welfare benefit plan (the "Plan"), and is subject to the requirements of the Employee Retirement Income Security Act of 1974, as amended (ERISA). References in this EOC to the "Administrator" mean BlueCross BlueShield of Tennessee, Inc., or BlueCross. ORAU has entered into an Administrative Services Agreement (ASA) with BlueCross for it to administer the claims Payments under the terms of the EOC, and to provide other services. BlueCross does not assume any financial risk or obligation with respect to Plan claims. BlueCross is not the Plan Sponsor, the Plan Administrator or the Plan Fiduciary, as those terms are defined in ERISA. ORAU is the Plan Fiduciary, the Plan Sponsor and the Plan Administrator. Other federal laws may also affect Your Coverage. To the extent applicable, the Plan complies with federal requirements.

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

Please read this EOC carefully. It describes the rights and duties of Members. It is important to read the entire EOC. Certain services are not covered by the plan. Other Covered Services are or may be limited. The Plan will not pay for any service not specifically listed as a Covered Service, even if a health care provider recommends or orders that non-covered service.

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

Any Grievance related to your coverage under this EOC shall be resolved in accordance with the "Grievance Procedure" section of this EOC.

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

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

Independent Licensee of the BlueCross BlueShield Association

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

Relationship With Network Providers

1. Independent Contractors

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

While the administrator has the authority to make benefit and eligibility determinations and interpret the terms of Your Coverage, ORAU, as the Plan Administrator as that term is defined in ERISA, has the discretionary authority to make the final determination regarding the terms of Your Coverage ("Coverage Decisions"). Both the administrator and ORAU make Coverage Decisions based on the terms of this EOC, the ASA, the

administrator's participation agreements with Network Providers, the administrator's internal guidelines, policies, procedures, and applicable State or Federal laws.

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

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

2. Termination of Providers' Participation

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

3. Provider Directory

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

NOTIFICATION OF CHANGE IN STATUS

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

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

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

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

Group Number: 89513

Benefits Effective: January 1, 2019

Benefits Available

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

Calculation of Coinsurance

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

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

Member's Responsibility

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

REWARDS OR INCENTIVES

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

ATTACHMENT C: PPO SCHEDULE OF BENEFITS

Group Name: Oak Ridge Associated Universities
Group Number: 89513
Effective Date: January 1, 2019

The Employer has selected the Blue Network P Provider network. To receive the maximum benefit from Your PPO Plan, make sure Your Provider is a member of the Blue Network P Provider network.

Covered Services	In-Network Benefits for Covered Services received from Network Providers	Out-of-Network Benefits for Covered Services received from Out-of-Network Providers [1]
Practitioner Services in office (physician, specialist or nurse practitioner)		
Diagnosis and treatment of illness or injury Primary Care Practitioners All other Practitioners Physician assistants and nurse practitioners may be classified as Primary Care Practitioners or "All other Practitioners" depending on the nature of the services provided. Visits to a health department will be classified as a Primary Care Practitioner visit.	$20 Copayment per visit $40 Copayment per visit	60% of the Maximum Allowable Charge after Deductible
Maternity Services The Copayment applies to the initial office visit to confirm pregnancy. For benefits for subsequent prenatal visits, postnatal visits and the physician delivery charge, see **Inpatient Hospital Stays and Behavioral Health Services** in the section **Services Received at a Facility**. Benefits for specialty care, even if related to pregnancy, are considered as any other illness, and a separate Copayment will apply.	$20 Copayment per visit (PCP types) $40 Copayment per visit (Specialists)	60% of the Maximum Allowable Charge after Deductible
Routine diagnostic services & injections	100% not subject to Deductible	60% of the Maximum Allowable Charge after Deductible
Advanced Radiological Imaging Services [3]	100% after $100 Copayment, not subject to Deductible	60% of the Maximum Allowable Charge after Deductible
Allergy Services (includes testing & injections)	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Office Surgery	100% not subject to Deductible	60% of the Maximum Allowable Charge after Deductible

Covered Services	In-Network Benefits for Covered Services received from Network Providers	Out-of-Network Benefits for Covered Services received from Out-of-Network Providers [1]
Chemotherapy/radiation therapy	100% not subject to Deductible	60% of the Maximum Allowable Charge after Deductible
Provider-Administered Specialty Pharmacy Products	100% after $125 Copayment, not subject to Deductible	60% of the Maximum Allowable Charge after Deductible
PhysicianNow Services Office services performed by licensed physicians via Your telephone, tablet or computer.	$20 Copayment per visit	No benefits available
Preventive Services		
Well Child Care	100% not subject to Deductible	60% of the Maximum Allowable Charge after Deductible
Well Care	100% not subject to Deductible	60% of the Maximum Allowable Charge after Deductible
Mammogram, Cervical cancer Screening and Prostate cancer Screening	100% not subject to Deductible	60% of the Maximum Allowable Charge after Deductible
Well woman exam (one annually)	100% not subject to Deductible	60% of the Maximum Allowable Charge after Deductible
Preventive/Well Care Services Includes preventive health exam, screenings and counseling services. Tobacco use counseling performed in a primary care setting, limited to 8 visits per Annual Benefit Period; Alcohol misuse counseling performed in a primary care setting, limited to 8 visits per Annual Benefit Period; Dietary counseling for adults with hyperlipidemia, hypertension, obesity, Type 2 diabetes, coronary artery disease and congestive heart failure limited to 12 visits annually.	100% not subject to Deductible	60% of the Maximum Allowable Charge after Deductible
Screening colonoscopy	100% not subject to Deductible	60% of the Maximum Allowable Charge after Deductible
Immunizations	100% not subject to Deductible	60% of the Maximum Allowable Charge after Deductible
One (1) retinopathy screening for diabetics per Calendar Year	100% not subject to Deductible	60% of the Maximum Allowable Charge after Deductible

Covered Services	In-Network Benefits for Covered Services received from Network Providers	Out-of-Network Benefits for Covered Services received from Out-of-Network Providers [1]
Facility Services includes Behavioral Health		
Inpatient Hospital [2]	100% after $200 Copayment per admission, not subject to Deductible	60% of the Maximum Allowable Charge after Deductible
Inpatient Hospice [2]	100% not subject to Deductible	60% of the Maximum Allowable Charge after Deductible
Outpatient Surgery	100% after $100 Copayment, not subject to Deductible	60% of the Maximum Allowable Charge after Deductible
Skilled Nursing/Rehab [2]	100% not subject to Deductible	60% of the Maximum Allowable Charge after Deductible
Emergency Care Services (Whether the Practitioner is considered an Emergency physician and therefore reimbursable under this benefit is determined by the place of service on the claim.)	100% after $100 Copayment, not subject to Deductible	100% after $100 Copayment
ER Advanced Radiological Imaging Services [3]	100% not subject to Deductible	60% of the Maximum Allowable Charge after Deductible
Other Services		
Outpatient Chemotherapy and/or radiation	100% not subject to Deductible	60% of the Maximum Allowable Charge after Deductible
Allergy Testing including injections	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Ground Ambulance	80% of Billed Charges after Deductible	80% of Billed Charges after Deductible
Air Ambulance	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Advanced Radiological Imaging Services [3]	100% after $100 Copayment, not subject to Deductible	60% of the Maximum Allowable Charge after Deductible
Outpatient Sleep Studies	100% not subject to Deductible	60% of the Maximum Allowable Charge after Deductible
Durable Medical Equipment	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Prosthetics & Orthotics (includes cochlear implants)	80% after Deductible	60% of the Maximum Allowable Charge after Deductible

Covered Services	In-Network Benefits for Covered Services received from Network Providers	Out-of-Network Benefits for Covered Services received from Out-of-Network Providers [1]
Home Health Services [4]	100% not subject to Deductible	60% of the Maximum Allowable Charge after Deductible
Outpatient Hospice	100% not subject to Deductible	60% of the Maximum Allowable Charge after Deductible
Home Infusion Therapy	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Therapeutic Services [5]	80% after Deductible	60% of the Maximum Allowable Charge after Deductible

Services At Blue Distinction Centers

Inpatient Hospital Stays require Prior Authorization. See the Prior Authorization section for more information. The grid below details how facility charges will be paid when received at a designated facility.

	Benefits for Covered Services received from Blue Distinction Centers/Blue Distinction Centers+	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Bariatric Surgery	80% after Deductible	Not Covered	Not Covered

Schedule of Pharmacy Prescription Drug Coverage

	One month supply (Up to 30 days)	Two months' supply (31 to 60 days)	Three months' supply (61 to 90 days)
	Generic Drug/Preferred Brand Drug/Non-Preferred Brand Drug		
RX04 retail network	$10/$35/$55	N/A	N/A
Home Delivery Network	$10/$35/$55	$20/$70/$110	$20/$70/$110
Plus90 Network	$10/$35/$55	$20/$70/$110	$20/$70/$110
Out-of-Network	60% after Plan Deductible.		

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

Limited up to a 30-day supply per Prescription

	Generic Drug/Preferred Brand Drug/Non-Preferred Brand Drug
Specialty Pharmacy Network - Preferred	$125 Drug Copayment per Prescription
Out-of-Network	Not Covered

Additional Provisions

90-day supplies are available through the Mail Order Network and the Plus90 Network. See bcbst.com to locate network pharmacies and to learn more about the Mail Order Network.

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

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

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

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

Organ Transplant Services			
All Transplant Services, except kidney transplants All Transplant Services require Prior Authorization. If You use a facility outside of the Blue Distinction Centers for Transplants (BDCT) Network, benefits will be limited to the Transplant Maximum Allowable Charge (TMAC) unless the BDCT Network does not include a facility that performs Your specific transplant type. Call Our consumer advisors before any pre-transplant evaluation or other Transplant Service is performed to request Prior Authorization, and to determine if there are facilities available in the BDCT Network for Your specific transplant type. See the "Prior Authorization, Care Management, Medical Policy and Patient Safety" and "Organ Transplants – All Organ Transplants, Excluding Kidney" sections of this EOC for more information.[6]	**Blue Distinction Centers for Transplants (BDCT)**: 100% Network, Out-of-Pocket Maximum applies.	**Transplant Network** [7] 100% of the Transplant Maximum Allowable Charge (TMAC), Network Out-of-Pocket Maximum applies; amounts over TMAC do not apply to the Out-of-Pocket Maximum and are not covered.	**Out-of-Network Providers**: 60% of the Transplant Maximum Allowable Charge (TMAC), Out-of-Network Out-of-Pocket Maximum applies, amounts over TMAC do not apply to the Out-of-Pocket and are not covered.
Kidney Transplant Services All Transplant Services require Prior Authorization. Call Our consumer advisors before any pre-transplant evaluation or other Transplant Service is performed to request Prior Authorization. [6]	**Network Providers:** 100% Network Out-of-Pocket Maximum applies.		**Out-of-Network Providers**: 60% of Maximum Allowable Charge (MAC), Out-of-Network Out-of-Pocket Maximum applies, amounts over MAC do not apply to the Out-of-Pocket and are not covered.

Other Information		
Lifetime Maximum	Unlimited	
Dependent Age Limit	Covered through the end of the month they reach age 26.	
• Individual Deductible • Family Deductible	\$500 \$1,000	\$1,000 \$2,000
• Individual Out-of-Pocket • Family Out-of-Pocket	\$2,000 \$4,000	\$4,000 \$8,000

1. *Out-of-Network benefit payment based on BlueCross BlueShield of Tennessee Maximum Allowable Charge. You are responsible for paying any amount exceeding the maximum allowable charge.*

2. *Services require Prior Authorization. Out-of-Network benefits are provided at 50% when Prior Authorization is not obtained.*

3. *CT scans, MRIs, nuclear medicine, and other similar technologies.*
4. *Requires Prior Authorization.*
5. *Includes physical, speech, manipulative, and occupational therapy and cardiac and pulmonary rehabilitation.*
    - *Occupational, physical and speech therapy have unlimited visits.*
    - *Manipulative therapies and pulmonary rehabilitation are limited to 36 visits per therapy type.*
    - *Cardiac rehabilitation is limited to 60 visits.*
6. *All Organ Transplants require Prior Authorization. Benefits will be denied without Prior Authorization. Transplant Network Providers are different from Network Providers for other services. Call customer service before any pre-transplant evaluation or other transplant service is performed to request Authorization, and to obtain information about Transplant Network Providers. Network Providers that are not in the Transplant Network may balance bill the Member for amounts over TMAC not Covered by the Plan.*
7. *Network Providers not in Our Transplant Network include Network Providers in Tennessee and BlueCard PPO Providers outside Tennessee.*

The Dependent Child Limiting Age –Dependents are Covered through the end of the month they reach age 26.

OTHER PROVISIONS

Chiropractic treatment is limited to 36 visits per Member per Calendar Year.

PRESCRIPTION DRUGS DEFINITIONS

Definitions

1. **Average Wholesale Price** – A published suggested wholesale price of the drug by the manufacturer.
2. **Brand Name Drug -** a Prescription Drug identified by its registered trademark or product name given by its manufacturer, labeler or distributor.
3. **Compound Drug** – An outpatient Prescription Drug that is not commercially prepared by a licensed pharmaceutical manufacturer in a dosage form approved by the Food and Drug Administration (FDA) and contains at least one ingredient that cannot be dispensed without a Prescription.
4. **Drug Copayment** - The dollar amount specified herein that You must pay directly to the Network Pharmacy when the covered Prescription Drug is dispensed. The Drug Copayment is determined by the type of drug purchased, and must be paid for each Prescription Drug.
5. **Elective Drug** or **Non Preferred Brand Drug -** A Brand Name Drug that is not considered a Preferred Drug by Administrator. Usually there are lower cost alternatives to some Brand Name Drugs.
6. **Experimental and/or Investigational Drugs** – Drugs or medicines that are labeled: Caution – limited by federal law to Investigational use.
7. **Generic Drug -** a Prescription Drug that has the same active ingredients, strength or concentration, dosage form and route of administration as a Brand Name Drug. The FDA approves each Generic Drug as safe and effective as a specific Brand Name Drug.
8. **Home Delivery Network** – BlueCross BlueShield of Tennessee's (BlueCross) network of pharmaceutical providers that deliver prescriptions through mail service pharmacy facilities to Your home.
9. **Maximum Allowable Charge** – the amount that the Plan, at its sole discretion, has determined to be the maximum amount payable for a Covered Service. That determination will be based upon the Plan's contract with a Network Provider or the amount payable based on the Plan's fee schedule for the Covered Services rendered by Out-of-Network Providers.
10. **Network Pharmacy -** A Pharmacy that has entered into a Network Pharmacy Agreement with the Administrator or its agent to legally dispense Prescription Drugs toMembers, either in person or through home delivery..
11. **Out-of-Network Pharmacy** - A Pharmacy that has not entered into a service agreement with Administrator or its agent to provide benefits at specified rates to Members.
12. **Pharmacy/Pharmacies** - A state or federally licensed establishment that is physically separate and apart from the office of a Practitioner, and where Prescription Drugs are dispensed by a pharmacist licensed to dispense such drugs under the laws of the state in which he or she practices..
13. **Pharmacy and Therapeutics Committee or P&T Committee**– A panel of the Administrator's 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) Drug Formulary; (2) Preferred Brand Drug list; (3) Prior Authorization Drugs list; and (4) Quantity Limitation list. The P&T Committee may also set dispensing limits on medications.

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

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

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

17. **Prescription Contraceptive Drugs –** Prescription Drug products that are indicated for the prevention of pregnancy. The current list can be found on bcbst.com or by calling the number on the back of Your ID card.

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

19. **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.

20. **Prior Authorization Drugs** - Prescription Drugs that are only eligible for reimbursement after prior approval from BlueCross as determined by the P&T Committee.

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

22. **Specialty Drugs –** Injectable, infusion and select oral medications that require complex care, including special handling, patient education and continuous monitoring. Specialty Drugs are listed on the Administrator's Specialty Drugs list. Specialty Drugs are categorized as provider-administered or self-administered.

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

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

Drugs – Prescription Coverage

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

Prior Authorization may be required for certain Prescription Drugs.

1. Covered Services

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

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

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

- approved for use by the Food and Drug Administration (FDA);
- dispensed by a licensed pharmacist or dispensingPractitioner on or after the date Your Coverage begins;
- listed on the Preferred Formulary.

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

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

e. Medically Necessary and Medically Appropriate Prescription Drugs used during chemical dependency treatment.

f. Immunizations administered at a Network Pharmacy.

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

h. 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.

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

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

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

2. Exclusions

a. Prescription Drugs not on the Preferred Drug Formulary;

b. 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 EOC;

c. Prescription Drugs dispensed in a doctor's office except as otherwise Covered in the EOC;

d. any Prescription Drugs that exceeds Quantity Limits specified by the Administrator's P & T Committee;

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

f. any Prescription dispensed by or through a non-retail Internet Pharmacy;

g. medications intended to terminate a pregnancy;

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

i. artificial appliances;

j. allergen extracts;

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

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

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

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

o. Prescription Drugs used for the treatment of infertility;

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 Administrator's P & T Committee. Prescription Drugs that represent an advance over available therapy according to the P & T Committee will be reviewed within at least six (6) months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug, will be reviewed within at least twelve (12) months after FDA approval;

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

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

t. Specialty Drugs used to treat hemophilia filled or refilled at an Out-of-Network Pharmacy;

u. drugs used to enhance athletic performance;

v. Experimental and/or Investigational Drugs;

w. Provider-administered Specialty Drugs, as indicated on the Provider –administered Specialty Drugs list. Refer to the "Specialty Drugs" section of "Attachment A: Covered Services and Exclusions" for Provider-administered Specialty Drug benefit Coverage information;

x. Prescription Drugs or refills dispensed:

   – in quantities in excess of amounts specified in the Benefit payment section;

   – without Our Prior Authorization when required; or

   – that exceed any applicable Annual Maximum Benefit, or any other maximum benefit amounts stated in the EOC.

y. contraceptives that require administration or insertion by a Provider (e.g., non-drug devices, implantable products such as Norplant, except injectables), except as otherwise Covered in the EOC

z. Compound drugs, unless Medically Necessary and Medically Appropriate.

aa. Prescription Contraceptive Drugs and/or devices;

bb. 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.

cc. 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.

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

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

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

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

- **Specialty Drugs**

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

  1. Covered Services

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

     b. Self-administered Specialty Drugs as identified on the Drug Formulary, which can be found at bcbst.com or by calling the number on the back of Your ID card.

  2. Exclusions

     a. Self-administered Specialty Drugs.

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

BLUE DISTINCTION® CENTERS

The Blue Cross Blue Shield Association, in conjunction with BlueCross BlueShield companies, developed the Blue Distinction Centers recognition program to identify hospitals with proven expertise in delivering specialty care.

Blue Distinction Centers for Specialty Care are nationally designated hospitals that demonstrate expertise in delivering patient care safely, effectively and cost efficiently for select specialty care procedures.

Blue Distinction Centers

Blue Distinction Centers (BDC) meet overall quality measures for patient safety and outcomes that are most closely correlated with positive patient outcomes. Although individual outcomes and experiences may vary, these hospitals are recognized for their **expertise** in delivering specialty care.

Blue Distinction Centers+

Blue Distinction Centers+ (BDC+) meet overall quality measures for patient safety and outcomes and also meet cost measures that address consumers' need for affordable healthcare. Although individual outcomes and experiences may vary, these hospitals are recognized for their expertise and efficiency in delivering specialty care.

Call Our consumer advisors to verify a facility's status as a **Blue Distinction Center** and **Blue Distinction Center+.**

Neither the Blue Cross Blue Shield Association nor any Blue Plans are responsible for damages or non-covered charges resulting from Blue Distinction or other Provider finder information or care received from Blue Distinction or other Providers.

SECTION I - ELIGIBILITY

COVERAGE FOR YOU

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

COVERAGE FOR YOUR DEPENDENTS

If the Subscriber is covered by this program, he or she may enroll eligible Dependents. The Subscriber and his or her Covered Dependents are also called Members. The names of Dependents for whom application for coverage is made must be listed on the application on file in Our records. Subsequent applications for Dependents must be submitted to BlueCross in writing.

TYPES OF COVERAGE AVAILABLE

Employee only

Employee + One Dependent

Employee + Two or More Dependents

APPLICATION FOR COVERAGE

Initial application by an Employee shall be made by completing and filing with ORAU an application form furnished by BlueCross. ORAU shall submit such form to BlueCross as a condition to coverage of such Employee and Dependents under this Contract. The names (and other information) of Dependents for whom application for coverage is made must be listed on the form.

APPLYING FOR COVERAGE

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

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

a. The Subscriber's legal spouse as defined by the Employer, which may include a Domestic Partner; or

b. The Subscriber's or the Subscriber's spouse's: (1) natural child; (2) legally adopted child (including children placed for the purpose of adoption); (3) step-child(ren); or (4) children for whom the Subscriber or Subscriber's spouse is the legal guardian; who are less than 26 years old; or

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

d. An Incapacitated Child of the Subscriber or Subscriber's spouse.

BlueCross' determination of eligibility under the terms of this provision shall be conclusive. BlueCross reserves the right to require proof of eligibility including, but not limited to, a certified copy of any Qualified Medical Child Support Order.

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

Enrollment upon Change in Status

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

1. You must request the change within 60 days of the change in status for the following events: (1) marriage or divorce; (2) death of the Employee's spouse or dependent; (3) change in dependency status; (4) Medicare eligibility; (5) coverage by another Payor; (6) birth or adoption of a child of the Employee; (7) termination of employment, or commencement of employment, of the Employee's spouse; (8) switching from part-time to full-time, or from full-time to part-time status by the Employee or the

Employee's spouse; (9) taking an unpaid leave of absence by the Employee or the Employee's spouse, or returning from unpaid leave of absence; (10) significant change in the health coverage of the Employee or the Employee's spouse attributable to the spouse's employment.

2. You must request the change within 60 days of the change in status for the following events: (1) loss of eligibility for Medicaid or CHIP coverage, or (2) becoming eligible to receive a subsidy for Medicaid or CHIP coverage.

It will be the Member's responsibility to notify Human Resources of any change in Dependent status (such as divorce, entitlement to Medicare, or disability) within 60 days of such changes(s).

EFFECTIVE DATE OF COVERAGE

Coverage under this plan will begin as follows:

You may elect Employee only, Employee + one Dependent or Employee + two or more Dependents Coverage when needed. An election must be made within 31 days of Your date of hire. Coverage will begin as of Your date of hire.

If you did not have a Dependent when you enrolled and later acquire a Dependent, you may elect Employee + one Dependent or Employee + two or more Dependents at that time. Coverage for the new Dependent will begin as of the date of enrollment. If the Subscriber is participating in the Section 125 Premium Conversion Plan, the Subscriber must enroll the new Dependent within 60 days.

If a person, other than a newborn child, becomes a Dependent after an Employee is covered under the existing coverage plan, the coverage for that Dependent will become effective on the date that Dependent is enrolled.

Coverage for a newborn child under existing coverage will begin as of the date of birth, assuming the newborn is subsequently enrolled within 60 days. Coverage for a child born to an Employee with Employee only Coverage only will not begin until the date the employee enrolls for conversion to Employee + one coverage. The conversion to Employee + one Coverage can be done prior to the birth of the child.

a. For an Employee and his/her Dependents who are eligible for coverage prior to the effective date of this Plan, coverage began on July 1, 2002, assuming the employee enrolls.

b. For an Employee and Dependents who were covered at the date of expiration of the prior coverage, coverage began under this plan on July 1, 2002.

c. For an individual who enrolls for coverage between the first (1st) and fifteenth (15th) of the month, full coverage will be provided as of the date of enrollment and a full premium will be paid. For an individual who enrolls for coverage after the fifteenth (15th) of the month, full coverage will be provided as of the date of enrollment, but no monthly premium will be paid until the first of the following month.

d. A covered individual cannot be enrolled as both an Employee and Dependent under this Plan.

POSTGRADUATE RESEARCH PARTICIPATION PROGRAMS PARTICIPANTS

Participants in ORAU's Postgraduate Research Participation Programs on appointments of one (1) year or longer become eligible on the initial date of their appointments. Participants are responsible for the payment of the full premium. Coverage for participants and their dependents will be the same as for all other covered individuals in the plan.

LEAVE OF ABSENCE

Continuous coverage during a leave of absence is permitted for up to 24 months if:

- ORAU continues to consider the covered individual an employee and the employee is eligible for all other employee benefits;
- the leave is for a specific period of time established in advance of the leave; and
- the purpose of the leave is documented.

A covered individual may apply for COBRA non-group coverage if the leave lasts more than 24 months.

RETIREMENT COVERAGE

Medical coverage may be continued for early retirees and their dependents until age sixty-five (65) or until each is covered by Medicare or another group medical insurance, whichever comes first. This Coverage is available for

early retirees with 10 or more years of service with ORAU.

Continuation Coverage (COBRA) may be elected by the covered individuals to extend coverage beyond the periods stated above. Premiums will be paid by the covered individuals.

COVERAGE FOLLOWING DEATH OF EMPLOYEE

Medical coverage for the spouse and eligible dependent children in force at the time of an employee's death will continue with the full premium paid by ORAU until the earliest of:

- Remarriage of the spouse, in which case coverage for all dependents ceases;
- A covered family member no longer meets the definition of a dependent under the Plan;
- One year from the employee's death.

Continuation Coverage (COBRA) may be elected by the covered individuals to extend coverage beyond the periods stated above. Premiums will be paid by the covered individuals.

COVERAGE WHILE ON ACTIVE UNIFORMED SERVICE DUTY

Employees, who are on uniformed service leave for 31 calendar days or less, and their dependents, will continue to cost share on premiums as if there had been no leave. After 31 days of leave without pay (LWOP) the Employee may keep the coverage if desired, however, the employee will be responsible for the total premium cost for continued coverage.

Employees who are on active uniformed service leave may discontinue coverage for themselves and their dependents during the military leave in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and subsequent modifications. At the time of return to work benefits will be reinstated.

COVERAGE FOLLOWING TOTAL DISABILITY

Medical coverage will be continued for a totally disabled employee (as determined by approval of LTD claim by ORAU's long term disability insurer) and his or her dependents with the full premium paid by ORAU until the earliest of:

- Twenty-four (24) months form the employee's total disability termination;
- The Employee ceases to be totally disabled;
- The covered member attains age sixty-five (65); or
- The covered member becomes eligible for Medicare, or begins participation in another Group Health Insurance Plan;
- The Employee or Dependent is expected to obtain Medicare coverage when eligible.

Continuation Coverage (COBRA) may be elected by the covered members to extend coverage beyond the period stated above. Premiums will be paid by the covered members.

A Member electing continuation coverage under this paragraph due to disability must provide notice of such disability to ORAU within 18 months of the date COBRA Continuation Coverage began.

Members enrolled as of the date their coverage would otherwise end have 60 days after such date, or the date they receive notice of their rights outlined in this paragraph and under COBRA, within which to elect continuation coverage.

As Plan Administrator, it will be ORAU's responsibility to give timely notice to Employees and eligible Dependents of their rights under this Paragraph and applicable law.

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

A Member may also be entitled to apply for an individual "Conversion" Contract as outlined in the General Provisions.

SECTION II - INTER-PLAN ARRANGEMENTS

I. Out-of-Area Services

Overview

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

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

Inter-Plan Arrangements Eligibility – Claim Types

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

A. BlueCard® Program

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

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

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to Us.

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

Estimated pricing and average pricing also take into account adjustments to correct for over- or

underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price We have used for Your claim because they will not be applied after a claim has already been paid.

B. Special Cases: Value-Based Programs

- *BlueCard® Program*

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

- *Value-Based Program Definitions*

  Accountable Care Organization (ACO): A group of healthcare providers who agree to deliver coordinated care and meet performance benchmarks for quality and affordability in order to manage the total cost of care for their member populations.

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

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

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

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

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

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

  Provider Incentive: An additional amount of compensation paid to a healthcare provider by a Blue

Cross and/or Blue Shield Plan, based on the provider's compliance with agreed-upon procedural and/or outcome measures for a particular group of covered persons.

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

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

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

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

D. Nonparticipating Providers Outside Our Service Area

1. **Member Liability Calculation**

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

2. **Exceptions**

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

E. BlueCross BlueShield Global® Core

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

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

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

- **Inpatient Services**

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

- **Outpatient Services**

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

- **Submitting a BlueCross BlueShield Global Core Claim**

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

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

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

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

A. Prior Authorization

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

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

- Inpatient Hospital and Inpatient Hospice stays (except initial maternity admissions)
- Skilled nursing facility and rehabilitation facility admissions
- Certain Outpatient Surgeries and/or procedures
- Certain air ambulance services
- Certain Specialty Drugs
- Certain Prescription Drugs (if Covered by a prescription drug card)
- Certain genetic testing

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

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

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

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

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

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

B. Care Management

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

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

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

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

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 the program are Covered, even though they may normally be excluded under this EOC.

C. Medical Policy

BlueCross medical policies address new and emerging medical technologies. Medical policy looks at the value of new and current medical science. Its goal is to make sure that Covered Services have proven medical value.

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

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

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

D. Patient Safety

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

Care Management services, emerging health care programs and alternative treatment plans will 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.

Health and Wellness Services

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.

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

Blue365® – The Blue365 Member discount program provides savings on a range of health-related products and services, including financial health, fitness gear, healthy eating, lifestyle, personal care, wellness, hearing aids, travel and recreation, weight loss programs and more.

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

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 1-888-308-7231or through web chat on BlueAccess at bcbst.com.

Healthy Maternity Management – This program provides You access to prenatal health education and telephonic support. You may be eligible for an electric breast pump at completion of the program. For more information, visit Your Member BlueAccess account at www.bcbst.com, and select My Health & Wellness, or contact Us at 1-800-818-8581.

PhysicianNow – This program provides You access to a licensed health care Practitioner via your telephone, tablet or computer. PhysicianNow Practitioners provide services for minor conditions such as allergies, bronchitis, skin infections, sore throat, cold and flu, ear infections and pink eye. Counseling services are available for anxiety, depression, child behavior issues, mood swings and other conditions. Not all conditions are appropriate for PhysicianNow consultation. Visit Your BlueAccess account at www.bcbst.com, for more information regarding services appropriate for PhysicianNow consultations.

Follow these steps to register and request a consultation:

Call 1-888-283-6691 or for hearing impaired TTY 1-800-770-5531, or visit Your Member BlueAccess account at www.bcbst.com, and select My Health & Wellness.

Complete and confirm Your medical history any time prior to Your first consultation.

Request a consultation from a licensed Practitioner.

PhysicianNow consultants do not replace emergency care or Your primary physician. Restrictions apply in some states where this service is not allowed. Prescriptions are issued only when clinically appropriate. Some

prescriptions, including controlled substances, are excluded from this service. Refer to “Attachment C: Schedule of Benefits” for benefit and cost share information.

SECTION IV - YOUR BENEFITS

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

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

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

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

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

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

HOSPITAL AND OTHER FACILITY PROVIDER SERVICES

Inpatient Services

Room, board, and general nursing care in a:

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

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

Blue Distinction Centers and Blue Distinction Centers+

Medically Necessary and Medically Appropriate services and supplies provided to You, when You receive services at a Blue Distinction Center or Blue Distinction Center+ for the following services: bariatric Surgery.

Prior Authorization is required for all inpatient services and certain outpatient services and must be obtained from the Plan, or benefits may be reduced or denied.

1. Covered Services
    a. Facility and Practitioner services will be reimbursed at the benefit level listed in "Attachment C: Schedule of Benefits,"

2. Exclusions

- Inpatient stays primarily for therapy (such as physical or occupational therapy).
- b. Services that could be provided in a less intensive setting.
- c. Blood or plasma that is provided at no charge to the patient.
- d. Rehabilitative therapies in excess of the benefits stated in the Therapeutic/Rehabilitative Services section.
- e. Services not received at a Blue Distinction Center or Blue Distinction Center+.

Outpatient Services

- Treatment of accidental injuries;
- Treatment of a sudden and serious illness;
- Removal of sutures, anesthetics and their administration, and other surgical services provided by a Hospital Employee other than the surgeon or assisting surgeon;
- Drugs, crutches, and medical supplies; and
- Pre-admission testing. Pre-Admission Testing is the performing of certain tests and studies that are required before a scheduled Hospital admission. Such tests and studies will be considered Covered Services when received in a Hospital prior to the date of the Member's admission as an Inpatient (and billed by such Hospital).
- Telehealth.

Emergency Services

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

Prior Authorization for Emergency Services will not be required. However, once the Member's medical condition has stabilized, Prior Authorization will be required for continuing Inpatient care or transfer to another facility. Benefits will be reduced to 50% for an Out-of-Network Provider if such Prior Authorization is not obtained.

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.

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES

Surgery

Operative and cutting procedures. To include:

- oral Surgery for the removal of impacted teeth;
- reconstructive breast Surgery as a result of a mastectomy (other than a lumpectomy);
- Surgery on the non-diseased breast needed to establish symmetry between the two breasts; and
- Surgery needed to restore an impaired bodily function if the condition occurs while a Member under this Contract and results from disease, birth defects, Surgery (excluding non-functional scar revision), or accidental injury.

Outpatient Surgery

Benefits will be provided as stated in the Schedule of Benefits for outpatient surgical procedures. The attending Physician must request Pre-Admission Certification when, in his or her opinion, the Member's medical condition requires Inpatient care. If any procedure is performed on an Inpatient basis without

Pre-Admission Certification, benefits will be reduced to 50% for an Out-of-Network Provider.

Multiple or Bilateral Surgical Procedures

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

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

Anesthesia

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

Physicians' Services

- A second and/or third surgical opinion received before Surgery
- Services of an attending Physician for Inpatient or Outpatient services, or consultation services when requested by the attending Physician
- Services of a Physician for treatment by x-ray, radium, or other radioactive substances
- Counseling services of a Physician, Licensed Psychologist designated, by law, as a health service provider, or Licensed Independent Practitioner of Social Work including treatment for drug addiction or alcoholism
- Injections and medications, except Specialty Pharmacy Products. (See Provider Administered Specialty Pharmacy Products section for information on Coverage).
- Telehealth.

Diagnostic Services

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

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

Maternity Services

Pregnancy and childbirth are covered on the same basis as an illness. Unless the mother and attending health care provider agree on an earlier date of discharge, benefits will be available for Hospital stays of not less than 48 hours following a conventional delivery or 96 hours following a cesarean delivery.

OTHER SERVICES

Allergy Testing (Including Injections and Allergy Extracts)

Allergy injections are not covered under the Prescription Drug Program; however, they will be covered at 80%, after the Deductible is satisfied if received from an In-Network Provider, or 60%, after the Deductible is satisfied if received from an Out-of-Network Provider.

Ambulance Services

Medically Necessary and Medically Appropriate ground or air transportation, services, supplies and medications by a licensed ambulance service when time or

technical expertise of the transportation is essential to reduce the probability of harm to You. Prior Authorization may be required for certain air ambulance services.

1. Covered

   - Ambulance Services - Air

   i. Medically Necessary and Medically Appropriate air transportation from the scene of an accident or Emergency to the nearest appropriate hospital. Air transportation is Covered only when Your condition requires immediate and rapid transport that cannot be provided by ground transport.

   - Ambulance Services - Ground

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

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

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

2. Exclusions

   - Transportation for the convenience of You, Your family and/or Your physician or other Provider.

   - Transportation that is not essential to reduce the probability of harm to the patient.

Urgent Care Center Services

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

1. Covered Services

   a. Diagnosis and treatment of illness or injury.

   b. Diagnostic services (such as x-rays and laboratory services).

   c. Injections and medications administered in an Urgent Care Center, except Specialty Drugs. See the "Specialty Drugs" section for more information on Coverage.

   d. Surgery and supplies.

2. Exclusions

   a. Rehabilitative therapies in excess of the terms of the "Therapeutic/Rehabilitative Services" section.

Blood or Blood Plasma, (including components and derivatives)

This will be an eligible expense when provided by a Hospital. This is not an eligible expense if blood is donated or replaced.

Cardiac Rehabilitation Therapy

Benefits are available for Cardiac Rehabilitation programs in accordance with the following defined progressive level of activity following coronary surgery or a heart attack.

Phase I--Activity when recuperating in a Hospital is treated as in-Hospital charges.

Phase II -- Expense consisting of exercise therapy, educational and medically monitored activity. Benefits are limited to 60 visits per Calendar Year and will be paid as Other Covered Services.

Phase III -- Non-medical activity --**No benefits are provided**.

Dental Care

Benefits are provided only for removal of impacted teeth or for dental work needed as a result of an Accidental Injury to the jaw, natural teeth, mouth, or face.

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

Benefits for Temporomandibular Joint Disorder (involving misalignment or imbalance in the way the upper and lower jaw meet) will be provided only for Phase I Therapy that includes:

- removable or fixed appliance designed primarily to stabilize the jaw joint and muscles—not to permanently alter the teeth; or
- physical therapy.

Benefits for "Phase II Therapy" (orthodontic, prosthodontic and restorative treatment or extractions) are specifically excluded.

Anesthesia for Dental Services

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

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

Diabetes Treatment

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

- prescribed and certified by a Physician as Medically Necessary; and
- provided by a Network Physician, Registered Nurse, Dietitian, or Pharmacist who has completed a diabetes patient management program recognized by the American Council on Pharmaceutical Education and the Tennessee Board of Pharmacy.

Services and supplies included under this provision shall include:

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

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

Durable Medical Equipment and Supplies

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

Benefits are also available to fit, adjust, repair, or replace Durable Medical Equipment, provided the need for this

arises from normal wear or the Member's physical development -- and not as a result of improved technology or loss, theft, or damage.

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

Eyeglasses or Contact Lenses

- one set following cataract Surgery

Home Health Care

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

Hospice Home Care

Hospice Home Care is an alternative to lengthy Inpatient treatment for terminally ill patients

- the patient's Physician must establish a plan of treatment
- an Approved Hospice must provide the services.

In-home services are available, such as:

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

The following will not be considered Covered Services:

- charges for services greater than the rate set in advance by the Contracting or Approved Hospice Agreement;
- housekeeping services, delivered or prepared meals, and convenience and comfort items not related to the palliation or management of the Member's terminal illness;
- supportive environmental items such as air conditioners, air fresheners, ramps, handrails, or intercom systems;
- transportation, chemotherapy, radiation therapy, enteral and parenteral feeding, private duty nursing, home hemodialysis, or medical research;
- visits made to the home by a Physician;
- Inpatient care at any facility. This includes Inpatient care provided in a Hospice, Hospital, Skilled Nursing Facility, intermediate care facility, or any other institution;
- Psychiatric Care;
- services provided by volunteer agencies or pastoral counseling services; and
- items, services, or supplies not specified as Covered Services.

Mammography Screening

Benefits are available for Medically Necessary and Medically Appropriate mammograms. Routine mammograms are provided in accordance with the following schedule:

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

Organ Transplants – <u>All Organ Transplants, Excluding Kidney</u>

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

tells You that You might need a transplant.

1. Prior Authorization.

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

2. Benefits

   Transplant benefits are different than benefits for other services.

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

   You have access to three levels of benefits:

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

   b. **Transplant Network:** If You want to receive the maximum benefit, You should use a facility in the BDCT Network. If You instead have a transplant performed at a facility in the Transplant Network (non-BDCT), the Administrator will pay at the benefit level listed in "Attachment C: Schedule of Benefits" for the Transplant Network. Benefits will be limited to the applicable Transplant Maximum Allowable Charge (TMAC). **When You use a facility in the Transplant Network, Network Providers have the right to bill You for any unpaid amount up to the contracted rate; this amount may be substantial. Not all Network Providers are in the Transplant Network. Please check with the Transplant Case Management department to determine if the Transplant Network is the best network available for Your specific transplant type.**

   c. **Out-of-Network transplants**: If You have a transplant performed at a facility that is not in the BDCT Network or Transplant Network, You

will receive the lowest level of benefits for Covered Services. The Administrator will pay at the benefit level listed in "Attachment C: Schedule of Benefits" for Out-of-Network Providers. Benefits will be limited to the applicable Transplant Maximum Allowable Charge (TMAC). **The Out-of-Network Provider has the right to bill You for any unpaid Billed Charges over the TMAC; this amount may be substantial. Please check with the Transplant Case Management department to determine if there are facilities available in the BDCT or Transplant Network for Your specific transplant type.**

d. Note: When the BDCT Network does not include a facility that performs Your specific transplant type, the Plan will pay at the benefit level listed in "Attachment C: Schedule of Benefits" for either the Transplant Network or for Out-of-Network Provider, based on the facility that is used. Benefits will NOT be limited to a Transplant Maximum Allowable Charge (TMAC). **If You use a facility in the Transplant Network, Network Providers have the right to bill You any unpaid amount up to the contracted rate. If you use an Out-of-Network facility, Out-of-Network Providers have the right to bill You for any unpaid Billed Charges. These amounts may be substantial. Please check with the Transplant Case Management department to determine if there are facilities available in the BDCT Network for Your specific transplant type.**

3. Covered Services

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

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

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

4. Organ and Tissue Procurement

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

services directly related to the Transplant itself:

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

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

5. Travel Expenses

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

- Covered travel expenses must be approved by the Transplant Case Management department and include travel to and from the facility in the BDCT Network for a Covered transplant procedure and required post-transplant follow-up. Any travel expenses for follow-up visits occurring more than 12 months from the date of the transplant are not Covered.
- Covered travel expenses will be limited as stated below:
  - Meals and lodging expenses, limited to $150 per day
  - The aggregate limit for travel expenses, including meals and lodging, is $10,000 per Covered transplant.

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

6. Exclusions

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

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

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

c. Non-Covered Services;

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

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

f. Payment to an organ donor or the donor's family as compensation for an organ, or Payment required to obtain

written consent to donate an organ;

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

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

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

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

7. **Organ Transplants – Kidney**

Medically Necessary and Medically Appropriate kidney transplant and related services.

You are encouraged to contact Our Transplant Case Management department by calling the number on the back of Your Member ID card as soon as Your Practitioner tells You that You might need a kidney transplant.

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

1. Covered Services

   a. Room and board; general nursing care; medications; injections; diagnostic services; and special care units.
   b. Attending Practitioner's services for professional care.

2. Kidney Procurement

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

   a. Donor search.
   b. Testing for donor's compatibility.
   c. Removal of the kidney from the donor's body.
   d. Preservation of the kidney.
   e. Transportation of the kidney to the site of transplant.
   f. Donor follow-up care directly related to the kidney donation, except as otherwise indicated under Exclusions.

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

3. Travel Expenses for Kidney Recipients

   Covered travel expenses must be approved by the Transplant Case Management department and

include travel to and from the facility for a Covered kidney transplant procedure and required pre-testing and post-transplant follow-up. Any travel expenses for follow-up visits occurring more than 12 months from the date of the kidney transplant are not Covered. In many cases, travel will not be approved for kidney transplants.

a. Covered 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, including meals and lodging, is $10,000 per Covered kidney transplant.

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

4. Travel Expenses for Live Kidney Donors

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

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

   a. Covered 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, including meals and lodging, is $5,000 per kidney donation.

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

5. Exclusions

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

   a. Kidney transplant and related services, including donor services, which did not receive Prior Authorization.

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

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

   d. Any non-human, artificial or mechanical kidney not determined to be Medically Necessary.

   e. Payment to an organ donor or the donor’s family as compensation for a kidney, or

payment required to obtain written consent to donate a kidney.

f. Removal of a kidney from a Member for purposes of transplantation into another person, except as Covered by the kidney procurement provision as described above.

g. Complications, side effects or injuries as a result of kidney donation.

Outpatient Private Duty Nursing

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

Preventive Services

Medically Necessary and Medically Appropriate services for assessing physical status and detecting abnormalities. The frequency of visits and services is based on guidelines from BlueCross' Medical Policy guidelines.

1. Covered

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

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

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

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

- Lactation counseling by a trained provider during pregnancy or in the post-partum period, and manual breast pump.

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

2. Exclusions

1. Office visits, physical exams and related immunizations and tests when required solely for: (1) sports; (2) camp; (3) employment; (4) travel; (5) insurance; (6) marriage or legal proceedings.
2. 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.
3. Rehabilitative therapies in excess of the limitations of the Therapeutic/ Rehabilitative benefit.
4. Dental procedures, except as otherwise indicated in this EOC.

Colonoscopy

Benefits will be provided at 100%, not subject to the Deductible, for one routine Colonoscopy beginning at age 50, limited to one every five years. The service must be performed by a Network Provider to be Covered at 100%, not subject to the Deductible.

Prosthetic Appliances

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

Pulmonary Rehabilitation (Limited to 36 visits per calendar year)

Pulmonary rehabilitation is defined as a multidisciplinary approach to the rehabilitation of individuals who are diagnosed with a chronic pulmonary disease. Pulmonary rehabilitation programs include exercise training, psychosocial support, education and follow up. All of these components are intended to improve the individuals functioning and quality of life. Individuals must be medically stable and without limitations by another medical/psychological problem.

Outpatient pulmonary rehabilitation for the treatment of a documented diagnosis of severe to moderately severe chronic obstructive pulmonary disease (COPD), either emphysema or chronic bronchitis, is considered medically necessary if the medical appropriateness criteria are met.

Therapy Services

- **chemotherapy** -- treatment of malignant disease by chemical or biological agents
- **dialysis** -- treatment of a kidney ailment, including the use of an artificial kidney machine
- **Home Infusion Therapy** -- treatment that involves the continuous slow introduction of a solution into the body
- **occupational therapy** -- treatment that involves the use of activities designed to restore, develop and/or maintain a person's ability to accomplish those daily living tasks necessary to a particular occupational role.
- **physical therapy** -- treatment to relieve pain, restore bodily function, and prevent disability following illness, injury, or loss of a body part
- **radiation therapy** -- treatment of disease by x-ray, radium, or radioactive isotopes
- **respiratory therapy** -- introduction of dry or moist gases into the lungs

- **speech therapy** -- Speech therapy is Covered for restoration of speech, but not for development of speech, and is limited to Coverage for disorders of articulation and swallowing, following an Acute illness, Acute injury, stroke, or congenital anomaly.

Drugs – Medical Coverage

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

1. Covered Services

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

   b. Pharmaceuticals that are dispensed or intended for use while You are confined in a hospital, skilled nursing facility or other similar facility.

2. Exclusions

   a. Prescription drugs except as indicated in this EOC.

   b. Those pharmaceuticals that may be purchased without a Prescription.

SECTION V - LIMITATIONS/EXCLUSIONS

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

EXCLUSIONS

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

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

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

    - disease;
    - birth defect;
    - Surgery (excluding non-functional scar revision); or
    - Accidental Injury.
11. self-treatment or services provided by any person related to the Member by blood or marriage, including the Member's spouse, parent, child, legal guardian, aunt, uncle, stepchild, or any person who resides in the Member's immediate household
12. services rendered by other than a Hospital, Physician or Other Provider(s) specified in this Plan
13. services paid under any other group, blanket or franchise insurance coverage; any other Blue Cross or Blue Shield group health plan, other health insurance plan, union welfare plan, or labor-management trust plan
14. personal hygiene and convenience items (such as air conditioners, humidifiers, or physical fitness equipment)
15. Charges for telephone consultations, e-mail or web based consultations, except as may be provided for by specially arranged Care Management programs, health and wellness programs, or emerging health care programs as described in the "Prior Authorization, Care Management, Medical Policy and Patient Safety" and "Health and Wellness Services" section of this EOC or in accordance with the Covered Services for Telehealth in the "Attachment A:

Covered Services and Exclusions" section of this EOC.

16. Hospital admissions that are primarily for diagnostic studies
17. Custodial Care
18. routine foot care, or the treatment of flat feet, corns, bunions, calluses, toe nails, fallen arches, weak feet, and chronic foot strain, unless the treatment is an approved surgical procedure
19. foot orthotics, shoe inserts and custom made shoes, except as required by law for diabetic patients or as part of a leg brace
20. services or supplies for dental care, except as specified
21. eyeglasses, contact lenses, and examinations for and the fitting of eyeglasses and contact lenses
22. hearing aids and examinations for and the fitting of hearing aids;

    Hearing aids shall include a conventional device to restore or enhance the patient's ability to hear. However, benefits for certain surgical procedures to restore hearing may be available if approved as Medically Necessary.
23. Hospital admissions primarily for physical therapy

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

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

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

    - treatment to correct a previous tubal pregnancy, and
    - treatment by ovulatory drugs (such as clomid) or hormonal treatment used primarily to treat irregular menstrual periods.
27. induced abortion unless: (1) the health care Practitioner certifies in writing that the pregnancy would endanger the life of the mother; or (2) the fetus is not viable; or (3) the pregnancy is a result of rape or incest; or (4) the fetus has been diagnosed with a lethal or otherwise significant abnormality.
28. services covered under Medicare, except as required by applicable state or federal law
29. non-medical self-care or self-help training and any related diagnostic testing or medical social services
30. any services or supplies designed to correct refractive errors of the eyes, except Surgery for removal of cataracts (including surgical implant of a prosthetic lens following cataract extraction)
31. an artificial heart or any other artificial organ, or any associated expense
32. services or supplies for the reversal of sterilization
33. services or supplies incurred after a Concurrent Review determines the services and supplies are no longer Medically Necessary
34. charges in excess of the Maximum Allowable Charge for Covered Services
35. benefits for Phase II Therapy connected with temporomandibular

joint disorders, including orthodontics, prosthodontic and restorative treatment or extractions

36. services rendered for or in connection with physical therapy that consist primarily in the application, supervision, or direction in the use of exercise or physical fitness equipment--whether or not such services are rendered by an Eligible Provider

37. any balance of charges, Deductibles, or Coinsurance resulting from a Member's failure to comply with applicable requirements of any other individual or group health plan, including: Prior Authorization, second surgical opinion consultation, Outpatient Surgery, or concurrent care review programs

38. any charges for services and supplies rendered to a Member that require the Prior Authorization of BlueCross BlueShield of Tennessee, where such Prior Authorization is not given

39. services or supplies rendered prior to the Effective Date or after a Member's coverage is terminated, except as otherwise specified

40. room, board, and general nursing care rendered on the date of discharge, unless both admission and discharge occur on the same day

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

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

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

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

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

46. for any care or treatment involving acupuncture

47. replacement of implanted cataract lenses

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

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

50. Human growth hormones, unless covered under the Prescription Drug program in this EOC.

51. Methadone and methadone maintenance therapy.

52. Charges related to surrogate pregnancy when the surrogate mother is not a Covered Member under this Plan.

53. Compound drugs, unless Medically Necessary and Medically Appropriate.

54. Services considered Cosmetic, except when Medically Necessary and Medically Appropriate. This exclusion also applies to Surgeries t improve appearance following a prior Surgical Procedure, even if that prior procedure was a Covered Service. Services that could be considered Cosmetic include, but are not limited to, (1) breast augmentation; (2) sclerotherapy

injections, laser or other treatment of spider veins and varicose veins; (3) rhinoplasty; (4) panniculectomy/abdominoplasty; and (5) Botulinum toxin.

55. 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; (7) thighplasty; (8) brachioplasty; (9) keloid removal; (10) dermabrasion; (11) chemical peels; (12) lipectomy; and (13) laser resurfacing.
56. Unless Covered under the Blue Distinction Centers and Blue Distinction Centers+ section of "Attachment A: Covered Services," services or supplies, including bariatric Surgery, for weight loss or 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.
57. Unless Covered under the Blue Distinction Centers and Blue Distinction Centers+ section of "Attachment A: Covered Services," services or supplies related to complications of Cosmetic procedures, complications of bariatric Surgery; re-operation of bariatric Surgery or body remodeling after weight loss.

SECTION VI - CLAIMS AND PAYMENT

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

CLAIMS

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

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

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

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

CLAIMS BILLING

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

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

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

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

Not all Covered Services are available from Network Providers. There may be some Provider types that BlueCross do not contract with. These Providers are called Non-Contracted Providers. Claims for services received from Non-Contracted Providers are handled as described in sections a. and b. above. You are also responsible for complying with any of the Plan's medical management policies or procedures (including, obtaining Prior Authorization of such Services, when necessary).

You may request a claim form from Our customer service department. BlueCross will send You a claim form within 15 days. You must submit proof of payment acceptable to BlueCross with the claim form. BlueCross may also request additional information or

documentation if it is reasonably necessary to make a Coverage decision concerning a claim.

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. If this occurs:

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

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

c. 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.

PAYMENT

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

a. Out-of-Network Providers may or may not file Your claims for You. A completed claim form for Covered Services must be submitted in a timely manner. Payment for Covered Services may be made to either the Out-of-Network Provider or to You, at the Plan's discretion. You will be responsible for any unpaid Billed Charges. The Plan's Payment fully discharges its obligation related to that claim.

b. Non-Contracted Providers may or may not file Your claims for You. A completed claim form for Covered Services must be submitted in a timely manner. Payment for Covered Services may be made to either the Non-Covered Provider or to You, at the Plan's discretion. You will be responsible for any unpaid Billed Charges. The Plan's payment fully discharges Our obligation related to that claim.

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

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

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

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

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

"COMPLETE INFORMATION."

Whenever You need to file a claim, BlueCross can process it for You more efficiently if You complete a claim form. This will ensure that You provide all the information needed. Most providers will have claim forms, or You can request them from BlueCross.

Mail all claim forms to:

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

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

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

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

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

2. If you move, notify an ORAU Human Resources staff member of Your new address to make sure You receive claim payments and Explanations of Benefits (EOB) paid on Your behalf.

SECTION VII - COORDINATION OF BENEFITS

This EOC includes the following Coordination of Benefits (COB) provision, which applies when a Member has coverage under more than one group contract or health care "Plan." Rules of this Section determine whether the benefits available under this EOC are determined before or after those of another Plan. In no event, however, will benefits under this EOC be increased because of this provision.

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

1. **Definitions**

The following terms apply to this provision:

a. "Plan" means any form of medical or dental coverage with which coordination is allowed. "Plan" includes:

(a) group, blanket, or franchise insurance;

(b) a group BlueCross Plan, BlueShield Plan;

(c) group or group-type coverage through HMOs or other prepayment, group practice and individual practice plans;

(d) coverage under labor management trust Plans or employee benefit organization Plans;

(e) coverage under government programs to which an employer contributes or makes payroll deductions;

(f) coverage under a governmental Plan or coverage required or provided by law;

(g) medical benefits coverage in group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type coverages;

(h) coverage under Medicare and other governmental benefits; and

(i) any other arrangement of health coverage for individuals in a group.

"Plan" does not include individual or family:

(1) Insurance contracts;

(2) Subscriber contracts;

(3) Coverage through Health Maintenance (HMO) organizations;

(4) Coverage under other prepayment, group practice and individual practice plans;

(5) Public medical assistance programs (such as TennCare[sm]);

(6) Group or group-type hospital indemnity benefits of $100 per day or less;

(7) School accident-type coverages.

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

b. "This Plan" refers to the part of the employee welfare benefit plan under which benefits for health care expenses are provided.

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

c. Primary Plan/Secondary Plan.

(1) The order of benefit determination rules state whether This Plan is a "Primary Plan" or "Secondary Plan" as to another plan covering You.

(2) When This Plan is a Primary Plan, its benefits are determined before those of the Other Plan. We do not consider the Other Plan's benefits.

(3) When This Plan is a Secondary Plan, its benefits are determined after those of the Other Plan and may be reduced because of the Other Plan's benefits.

(4) When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more Other Plans, and may be a Secondary Plan as to a different Plan or Plans.

d. "Allowable Expense" means a necessary, reasonable and customary item of expense when the item of expense is covered at least in part by one or more Plans covering the Member for whom the claim is made.

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

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

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

2. **Order of Benefit Determination Rules**

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

a. Non-Dependent/Dependent

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

(1) if the person is also a Medicare beneficiary and,

(2) if the rule established by the Social Security Act of 1965 (as amended) makes Medicare secondary to the Plan covering the person as a Dependent of an active Employee, then the order of benefit determination shall be:

- benefits of the Plan of an active Employee covering the person as a Dependent;
- Medicare;
- benefits of the Plan covering the person as an Employee, Member, or Subscriber.

b. Dependent Child/Parents Not Separated or Divorced

Except as stated in Paragraph (c) below, when This Plan and another Plan cover the same child as a Dependent of different persons, called “parents”:

(1) The benefits of the Plan of the parent whose birthday falls earlier in a year are

determined before those of the Plan of the parent whose birthday falls later in that year; but

(2) If both parents have the same birthday, the benefits of the Plan that has covered one parent longer are determined before those of the Plan that has covered the other parent for a shorter period of time.

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

c. Dependent Child/Separated or Divorced Parents

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

(1) First, the Plan of the parent with custody of the child;

(2) Then, the Plan of the spouse of the parent with the custody of the child; and

(3) Finally, the Plan of the parent not having custody of the child.

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

(5) If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in Paragraph 2(b), Dependent Child/Parents Not Separated or Divorced.

d. Active/Inactive Employee

The benefits of a Plan that covers a person as an Employee who is neither laid off nor retired are determined before those of a Plan which covers that person as a laid off or retired Employee. If the Other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Rule is ignored.

e. Longer/Shorter Length of Coverage

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

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

(2) The start of the new Plan does not include:

- A change in the amount or scope of a Plan's benefits;
- A change in the entity that pays, provides, or administers the Plan's benefits; or
- A change from one type of Plan to another (such as, from a single Employer Plan to that of a multiple Employer plan.)

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

If the Other Plan does not contain provisions establishing the Order of Benefit Determination Rules, the benefits under the Other Plan will be determined first.

f. Plans with Excess and Other Non-conforming COB Provisions

Some Plans declare their coverage "in excess" to all Other Plans, "always Secondary," or otherwise not governed by COB rules. These Plans are called "Non-complying Plans."

Rules. This Plan coordinates its benefits with a Non-complying Plan as follows:

(1) If This Plan is the Primary Plan, it will provide its benefits on a primary basis.

(2) If This Plan is the Secondary Plan, it will provide benefits first, but the amount of benefits and liability of This Plan will be limited to the benefits of a Secondary Plan.

(3) If the Non-complying Plan does not provide information needed to determine This Plan's benefits within a reasonable time after it is requested, This Plan will assume that the benefits of the Non-complying Plan are the same as the benefits of This Plan and provide benefits accordingly. However, this Plan must adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the Non-complying Plan.

(4) If:

(a) The Non-complying Plan reduces its benefits so that the Member receives less in benefits than he or she would have received had the Complying Plan paid, or provided its benefits as the Secondary Plan, and the Non-complying Plan paid or provided its benefits as the Primary Plan; and

(b) Governing state law allows the right of subrogation set forth below;

then the Complying Plan may advance to You or on Your behalf an amount equal to such difference. However, in no event shall the Complying Plan advance more than the Complying Plan would have paid, had it been the Primary Plan, less any amount it

previously paid. In consideration of such advance, the Complying Plan shall be subrogated to all Your rights against the Non-complying Plan. Such advance by the Complying Plan shall also be without prejudice it may have against the Non-complying Plan in the absence of such subrogation.

3. **Effect on the Benefits of this Plan**

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

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

(1) the benefits that would be payable for the Allowable Expenses under This Plan, in the absence of this COB provision; and

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

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

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

c. The administrator will not, however, consider the benefits of the Other Plan(s) in determining benefits under This Plan when:

(1) the Other Plan has a rule coordinating its benefits with those of This Plan and such rule states that benefits of the Other Plan will be determined after those of This Plan; and

(2) the order of benefit determination rules requires Us to determine benefits before those of the Other Plan.

4. **Right to Receive and Release Needed Information**

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

5. **Facility of Payment**

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

6. **Right of Recovery**

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

a. The persons it has paid or for whom it has paid;

b. Insurance companies; or

c. Other organizations.

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

7. **Are You Also Covered by Medicare?**

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

SECTION VIII - GRIEVANCE

I. GRIEVANCE PROCEDURE

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

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

II. DESCRIPTION OF THE REVIEW PROCEDURES

A. Inquiry

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

B. First Level Grievance

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

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

1. Grievance Process

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

2. Written Decision

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

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

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

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

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

- A statement of the committee's understanding of Your Grievance;
- The basis of the committee's decision; and
- Reference to the documentation or information upon which the committee based its decision. You may receive a copy of such documentation or information, without charge, upon written request.

C. Second Level Grievance

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

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

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

Your decision concerning whether to file a second level Grievance has no effect on Your rights to any other benefits under the Plan. If You file a second level Grievance concerning an ERISA Action, the Plan agrees to toll any time defenses or restrictions affecting Your right to bring a civil

action against the Plan until the second level committee makes its decision. Any person involved in making a decision concerning Your Dispute (e.g. first level committee members) will not be a voting member of the second level Grievance committee.

1. Grievance Process

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

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

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

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

2. Written Decision

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

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

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

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

D. Independent Review of Medical Necessity Determinations

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

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

Plan, until the independent reviewer makes its decision.

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

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

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

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

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

SECTION IX - SUBROGATION AND RIGHT OF RECOVERY AND REIMBURSEMENT

A. Subrogation Rights

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

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

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

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

B. Priority Right of Reimbursement

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

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

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

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

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

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

<u>Notice and Cooperation</u>

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

on behalf of ORAU, deems necessary to protect the Plan's rights under this section.

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

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

Legal Action and Costs

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

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

Settlement or Other Compromise

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

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

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

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

The Covered Person agrees that the proceeds subject to the Plan's lien are Plan assets and the Covered Person will hold such assets as a trustee for the Plan's benefit and shall remit to the Plan, or its representative, such assets upon request. If represented by counsel, the Covered Person agrees to direct such counsel to hold the proceeds subject to the Plan's lien in trust and to remit such funds to the Plan, or its representative, upon request. Should the Covered Person violate any portion of this section, the Plan shall have a right to offset future benefits otherwise payable under this plan to the extent of the value of the benefits advanced under this section to the extent not recovered by the Plan.

SECTION X - TERMINATION OF MEMBER COVERAGE

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

- Coverage will terminate if:
  - the required premium charge or contribution is not paid, or
  - such person ceases to meet the eligibility requirements specified in the Schedule of Eligibility.
- If You elect continuation coverage as specified in a following section You must pay to ORAU monthly premium charges for such coverage. Initial premium charges for continuation coverage will be due no later than 45 days after the date continuation coverage is elected. ORAU will in turn remit to BlueCross such premium charges with payment of our regular billing.
- Dependent coverage will terminate the last day of the month in which the Dependent no longer meets the definition of eligible Dependent.
- All coverage provided under this plan will end effective the date of its termination. No benefits will be provided for any service or supply rendered after such date.
- If a Member does not follow program guidelines, including paying required Copayments or Coinsurance to Participating Providers, BlueCross, in its sole discretion, has the right to cancel a Member's coverage with 30 days' notice, subject to the Member's grievance rights.
- At its discretion, the Plan may terminate or Rescind Coverage if You have made an intentional misrepresentation of material fact or committed fraud in connection with Coverage. If applicable, the Plan will return all Premiums paid after the termination date less claims paid after that date. If claims paid after the termination date are more than Premiums paid after that date, the Plan has the right to collect that amount from You or Your terminated dependents to the extent allowed by law. You will be notified thirty (30) days in advance of any Rescission.

BENEFITS AFTER COVERAGE ENDS

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

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

SECTION XI - CONTINUATION OF COVERAGE

Federal Law

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

1. Eligibility

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

   a. Subscribers. Loss of Coverage because of:

      (1) The termination of employment except for gross misconduct.

      (2) A reduction in the number of hours worked by the Subscriber.

2. Covered Dependents. Loss of Coverage because of:

   (1) The termination of the Subscriber's Coverage as explained in subsection (a), above.

   (2) The death of the Subscriber.

   (3) Divorce or legal separation from the Subscriber.

   (4) The Subscriber becomes entitled to Medicare.

   (5) A Covered Dependent reaches the Limiting Age.

3. Enrolling for COBRA Continuation Coverage

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

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

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

4. Payment

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

by the COBRA administrator on or before the due date, Coverage will be terminated, for cause, effective as of the last day for which Payment was received as explained in the Termination of Coverage Section.

5. Coverage Provided

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

6. Duration of Eligibility for COBRA Continuation Coverage

   COBRA Continuation Coverage is available for a maximum of:

   - 18 months if the loss of Coverage is caused by termination of employment or reduction in hours of employment; or

   - 29 months of Coverage. If, as a qualified beneficiary who has elected 18 months of COBRA Continuation Coverage, You are determined to be disabled within the first 60 days of COBRA Continuation Coverage, You can extend Your COBRA Continuation Coverage for an additional 11 months, up to 29 months. Also, the 29 months of COBRA Continuation Coverage is available to all non-disabled qualified beneficiaries in connection with the same qualifying event. "Disabled" means disabled as determined under Title II or XVI of the Social Security Act. In addition, the disabled qualified beneficiary or any other non-disabled qualified beneficiary affected by the termination of employment qualifying event must:

     (1) Notify the Employer or the administrator of the disability determination within 60 days after the determination of disability, and before the close of the initial 18-month Coverage period; and

     (2) Notify the Employer or the administrator within 30 days of the date of a final determination that the qualified beneficiary is no longer disabled; or

   - 36 months of Coverage if the loss of Coverage is caused by:

     (1) the death of the Subscriber;

     (2) loss of dependent child status under the Plan;

     (3) the Subscriber becomes entitled to Medicare; or

     (4) divorce or legal separation from the Subscriber; or

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

7. Termination of COBRA Continuation Coverage

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

   - The Payment for such Coverage is not submitted when due; or

   - You become Covered as either a Subscriber or dependent by another group health care plan, and that coverage is as good as or better than the COBRA Continuation Coverage; or

   - The ASA is terminated; or

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

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

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

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

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

9. Continued Coverage During a Military Leave of Absence

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

10. Continued Coverage During Other Leaves of Absence

    The Employer may allow Subscribers to continue their Coverage during other leaves of absence. Please check with the human resources department to find out how long Subscribers may take a leave of absence.

    Subscribers also have to meet these criteria to have continuous Coverage during a leave of absence:

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

    A Subscriber may apply for COBRA Continuation if the leave lasts longer than allowed by the Employer.

11. The Trade Adjustment Assistance Reform Act of 2002

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

SECTION XII - DEFINITION OF TERMS

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

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

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

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

- A determination by a health carrier or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health carrier's health benefit plan does not meet the health carrier's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit;
- The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier of a Covered person's eligibility to participate in the health carrier's health benefit plan; or
- Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment for, in whole or in part, a benefit.

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

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

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

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

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

Behavioral Health Services – Any services or supplies to treat a mental or emotional condition or substance use disorder.

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

Blue Distinction Centers for Transplants (BDCT) Network – A network of facilities and hospitals contracted with BlueCross (or with an entity on behalf of BlueCross) to provide Transplant Services for some or all organ and bone marrow transplant procedures Covered under this EOC, excluding kidney transplants. Facilities obtain designation as a BDCT by transplant type; therefore, a hospital or facility may be classified as a BDCT for one type of organ or bone marrow transplant procedure but not for another type of transplant. This designation is important as it impacts the level of benefit You will receive.

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

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

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

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

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

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

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

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

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

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

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

All Copayments apply toward satisfying the Out-of-Pocket Maximum.

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

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

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

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

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

be considered when determining if the Member has satisfied a Deductible.

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

Dependent - spouse (under a legally existing marriage) and children. Children include the natural, legally adopted, foster or step-child(ren) of You and Your spouse; children placed with Your or Your spouse pending adoption; children for whom You or Your spouse is court-appointed legal guardian; children of You or Your spouse for whom a Qualified Medical Child Support Order has been issued; or an Incapacitated Child of Your of Your spouse.

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

Durable Medical Equipment - equipment that:

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

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

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

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

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

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

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

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

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

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

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

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

- The Provider must be licensed or certified by the state in which they are practicing;
- services provided must be within the scope of his/her licensure; and

- coverage of the provider must be required by state law of the state in which he/she is practicing; or
- be a Provider (such as Physician Assistants) approved by BlueCross.

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

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

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

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

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

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

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

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

ERISA – The Employee Retirement Income Security Act of 1974, as amended.

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

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

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

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

Freestanding Dialysis Facility - a facility Other Provider that provides kidney dialysis treatment, maintenance, and training to patients on an Outpatient or Home Health Care basis.

To be eligible for payment under this coverage, the facility must be approved by Medicare.

Health Care Professional - a podiatrist, dentist, chiropractor, nurse midwife, registered nurse, optometrist, or other person licensed or certified to practice a health care profession, other than medicine or osteopathy, by Tennessee or the state in which such provider practices.

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

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

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

Approved Hospice refers to a Hospice that:

- is licensed by and, if legally required, has been issued a Certificate of Need from the state in which it is operating,
- is certified as a Home Health Care Agency under Title XVIII and Title XIX of the Social Security Act,

- is eligible for accreditation by the Joint Commission on Accreditation of Healthcare Organizations as a Hospice, and
- provides in-home health care services that conform to the standards of a Hospice Program of Care as adopted by the Board of Directors of the National Hospice Organization.

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

HR – Human Resources department of Oak Ridge Associated Universities.

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

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

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

Inpatient - an individual who is admitted as a registered bed patient in a Hospital or Skilled Nursing Facility and for whom a room and board charge is made. This term is also used to describe services provided in a Hospital or Skilled Nursing Facility setting.

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

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

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

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

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

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

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

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

   ii. The evidence should demonstrate that the technology could measure or alter the physiological changes

related to a disease, injury, illness, or condition. In addition, there should be evidence or a convincing argument based on established medical facts that such measurement or alteration affects health outcomes.

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

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

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

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

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

a. Your medical records, or

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

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

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

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

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

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

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

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

Maintenance Care – Medical services Prescription Drugs, supplies and equipment for chronic, static or progressive medical conditions where the medical services: (1) fail to contribute toward cure; (2) fail to improve unassisted clinical function; (3) fail to significantly improve health; and (4) are indefinite or long-term in nature. Maintenance Care includes, but is not limited to, Prescription Drugs used to treat chemical and methadone dependency maintenance and skilled services/therapies.

Maximum Allowable Charge - The amount that the administrator, at its discretion, has determined to be the maximum amount payable for a Covered Service. For Covered Services provided by Network Providers, that determination will be based upon the administrator's contract with the Network Provider for Covered Services rendered by that Provider. For Covered Services provided by Out-of-Network Providers, the amount payable will be based upon the administrator's Out-of-Network fee schedule for the Covered Services rendered by Out-of-Network Providers. 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 (a) the median amount negotiated with Network providers for the Emergency Care Services furnished, (b) the amount for the Emergency Care Services calculated using the same method generally used to determine payments

for Out-of-Network services, or (c) the amount that would be paid under Medicare for the Emergency Care Services.

Maximum Amount - the total dollar amount of benefits available under this plan.

The Maximum amount (as stated in the Schedule of Benefits) will be subject to (and reduced by) amounts paid in any and all contract years preceding the Effective Date of this coverage, provided the Member has had continuous coverage under group health contract(s) between BlueCross and ORAU during such years.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

identify each health plan to which such order applies.

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

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

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

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

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

will be considered a Skilled Nursing Facility under this plan.

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

Specialty Pharmacy Products – Injectable, infusion and select oral medications that require complex care, including special handling, patient education and continuous monitoring. Specialty Pharmacy Products are listed on the administrator's Specialty Pharmacy Products list. Specialty Pharmacy Products are categorized as provider-administered or self-administered.

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

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

Surgery - the following:

operative and cutting procedures, including:

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

Telehealth – Remote consultation that meets Medical Necessity criteria.

Totally Disabled or Total Disability – Either:

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

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

Transplant Maximum Allowable Charge (TMAC) – The amount that the administrator, in its sole discretion, has determined to be the maximum amount payable for Transplant Services and Covered transplant-related care. Each type of Organ Transplant has a separate TMAC; however, TMAC does not apply to kidney transplants.

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

Transplant Services – Medically Necessary and Medically Appropriate Services listed as Covered under the "Organ Transplants – All Organ Transplants, Excluding Kidney" and "Organ Transplants – Kidney" sections in "Attachment A: Covered Services and Exclusions" of this EOC.

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

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

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

SECTION XIII - STATEMENT OF ERISA RIGHTS

For the purposes of this Section, the term "Plan" means the employee welfare benefit plan sponsored by the Plan Sponsor (usually, ORAU.) The Employee Retirement Income Security Act of 1974 (ERISA) entitles You, as a Member of the group under this plan to:

1. Examine, without charge, at the office of the Plan Administrator (Plan Sponsor, usually ORAU) and at other specified locations, such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration;

2. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator (Plan Sponsor, i.e., ORAU). The Plan Administrator may make a reasonable charge for these copies; and

3. Receive a summary of the plan's annual financial report. The Plan Administrator (Plan Sponsor, usually ORAU) is required by law to furnish each participant with a copy of this summary annual report.

4. Obtain a statement telling You whether You have a right to receive a pension at normal retirement age and if so, what Your benefits would be at normal retirement age if You stop working under the Plan now. If You do not have a right to a pension, the statement will tell You how many more years You have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The Plan must provide the statement free of charge.

5. Continue Your health care coverage if there is a loss of coverage under the Plan as a result of a qualifying event. You may have to pay for such coverage. Review the Continuation of Coverage section of this EOC for the rules governing your COBRA continuation coverage rights.

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

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

The court will decide who should pay court costs and legal fees. If You are successful,

the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees; for example, it may order You to pay these expenses if it finds Your claim is frivolous.

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

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

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

IMPORTANT NOTICE FOR MASTECTOMY PATIENTS

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

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

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

GENERAL LEGAL PROVISIONS INDEPENDENT LICENSEE OF THE BLUECROSS BLUESHIELD ASSOCIATION

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

RELATIONSHIP WITH NETWORK PROVIDERS

A. Independent Contractors

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

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

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

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

B. Termination of Providers' Participation

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

C. Provider Directory

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

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

The company office or person to contact about coverage is:

_____

Name:

_____

Address:

_____

_____

_____

Phone:

The BlueCross BlueShield Plan to contact is:

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

The Subscriber Number shown on my identification card is:

_____

The "Effective Date" when my coverage begins is:

_____

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