# Evidence of Coverage

Health Benefit Plan

**CO-OP HEALTH & WELFARE PLAN AND TRUST -- HDHP Plan -- 2025**

of Tennessee

COMM-662 (8/16)
Health EOC - Members

# 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*.

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[1]. BlueCross does not exclude people or treat them less favorably because of race, color, national origin, age, disability or sex.

BlueCross:

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

If you need these reasonable modifications, appropriate auxiliary aids and services, or language assistance 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 Grievance; 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).

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

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

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association.

BlueCross BlueShield of Tennessee is a Qualified Health Plan Issuer in the Health Insurance Marketplace.

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

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

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

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

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

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

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

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

ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາ ພາສາລາວ, ມີການບໍລິການ ຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການທີ່ ເໝາະສົມໃຫ້ທ່ານ. ກະລຸນາໂທຫາເບີຂອງຝ່າຍບໍລິການສະມາຊິກ ທີ່ມີຢູ່ດ້ານຫຼັງບັດ ID ສະມາຊິກຂອງທ່ານ ຫຼື 1-800-565-9140 (TTY: 1-800-848-0298).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# NOTICE

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

**CUSTOMER SERVICE DEPARTMENT**
**BLUECROSS BLUESHIELD OF TENNESSEE, INC.,**
**ADMINISTRATOR**
**1 CAMERON HILL CIRCLE**
**CHATTANOOGA, TENNESSEE 37402-2555**
**(800) 565-9140**

**TABLE OF CONTENTS**

## INTRODUCTION

This Evidence of Health Coverage (this "EOC") was created for the Co-op Health & Welfare Plan and Trust (the "Trust") as part of an employee welfare 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. The Trust 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. The Trust is the Plan Fiduciary and the Plan Administrator. The Tennessee Farmers' Cooperative is the Plan Sponsor. Other federal laws may also affect Your Coverage. To the extent applicable, the Plan complies with federal requirements. 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 EOC or other description of benefits You have previously received from the Plan.

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

The Trust has delegated discretionary authority to make any benefit determinations to the administrator, the Trust also has the authority to make any final Plan determination. The Trust, 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 Trust's benefit plan is subject to ERISA. The Trust has 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" section of this EOC.

The Trust has selected a High Deductible Health Plan (HDHP), which may be used with a Health Savings Account (HSA). It may be different from previous health plans You have had. HDHPs are described on the following page of this EOC.

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

## BENEFIT ADMINISTRATION ERROR

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

## 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.

## WHAT IS A HIGH DEDUCTIBLE HEALTH PLAN?

A High Deductible Health Plan (HDHP) has a higher Annual Benefit Period deductible than a typical health plan. When You are Covered under a HDHP, You may qualify for tax savings by contributing to a Health Savings Account (HSA).

An HSA is a personal tax-exempt trust or custodial account used to pay for qualified medical expenses. HSAs are regulated by the Internal Revenue Service (IRS). You should seek tax advice to see if You qualify for an HSA. An HSA is not a part of Your employer-sponsored and maintained benefit program.

If You have other health insurance Coverage, the other Coverage must be another High Deductible Health Plan in order to qualify for tax savings.

### How do Deductibles work with a HDHP?

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

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

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

## RELATIONSHIP WITH NETWORK PROVIDERS

### A. Independent Contractors

Network Providers are independent contractors and are not employees, agents or representatives of the administrator. Network 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 Trust and the administrator do not make medical treatment decisions under any circumstances.

While the administrator has the authority to make benefit determinations and interpret the terms of Your Coverage, the Trust, 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 Trust make Coverage Decisions based on the terms of this EOC, the ASA, the administrator's internal guidelines, policies, procedures and applicable State or Federal laws. The Trust retains the authority to determine whether You or Your dependents are eligible for Coverage.

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.

### 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.

## 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.

## OUR PAYMENT METHODS FOR NETWORK PROVIDERS

Our agreements with Network Providers include different payment arrangements. We use various alternative Provider payment methodologies including, but not limited to, Diagnosis Related Group (DRG) payments, discounted fee-for-service payments, patient-centered medical home programs, bundled payments for episodes of care, pay-for-performance initiatives, and other quality improvement and/or cost containment programs.

## 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 Employee Benefits Department when a Member changes:

- name;
- address;
- telephone number;
- employment; or
- status of any other health coverage the Member has.

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

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

## ELIGIBILITY

Any Employee of the Employer and his/her family dependents, who meet the eligibility requirements of this Section, will be eligible for Coverage if properly enrolled for Coverage, and upon payment of the required Payment for such Coverage. If there is any question about whether a person is eligible for Coverage, the Plan shall make final eligibility determinations in accordance with the requirements of this EOC.

### A. Subscriber

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

1. Be a full-time Employee of the Employer, who is Actively at Work; and
2. Satisfy all eligibility requirements of the Plan; and
3. Enroll for Coverage from the Plan by submitting a completed and signed Enrollment Form to the Plan. Employees can submit an Enrollment Form in any format agreed to by the Plan and Us (i.e., electronically, faxed, paper, etc.)

### B. Covered Dependents

To be eligible to enroll as a Covered Dependent, a Member must be listed on the Enrollment Form completed by the Subscriber, meet all dependent eligibility criteria established by the Employer, and be:

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

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

The Plan reserves the right to require proof of eligibility including, but not limited to, a certified copy of any Qualified Medical Child Support Order or certification of full-time student status.

### C. Waiting Period

The Plan has no Waiting Period. Each Employee's Coverage is effective on the first day of the month after he or she makes application, provided the application is received by the 19th day of the preceding month.

### D. Coverage For Retirees (The Trustees of the Plan have elected to discontinue this type of coverage effective January 1, 2028. At that time, any covered retirees who have not yet attained age 65, will become COBRA eligible.)

A Subscriber who qualifies as a Retiree may still be an eligible Employee under this EOC after leaving full time employment. A Retiree is defined as an Employee who:

- has a minimum of 20 consecutive years of service with the Employer; and
- has participated in the health coverage through the Co-op Health & Welfare Plan at least 5 consecutive years (60 consecutive months) immediately prior to retirement; and
- is at least age 62 and not eligible for Medicare.

Such Retirees will be eligible to participate in the Co-op Health & Welfare Plan until age 65 or the date first eligible for Medicare, whichever occurs first. If the Retiree is still eligible, an eligible Dependent will be eligible to participate until age 65 or the date first eligible for Medicare, whichever occurs first.

Retirees may be required to participate in the cost of coverage during this period, depending on the sole discretion of the Employer.

Dependents will have access to coverage through COBRA, whether or not the Employee elects to keep the COBRA plan upon reaching age 65.

### E. Coverage For Disabled Persons

An Employee with less than six months of employment who has participated in the health coverage through the Co-op Health & Welfare Plan and becomes disabled will have Coverage through the end of the month that follows the last day worked. The affected individual is then eligible to continue Coverage under COBRA Continuation Coverage, provided the individual enrolls and pays

all contributions timely. Continuation of Coverage is subject to all COBRA Continuation Coverage rules and regulations.

An Employee with at least six months of employment with less than five years participation in the Co-op Health & Welfare Plan who becomes disabled will have Coverage through the end of the month that follows the month of the last day worked or following the Employer's leave policy. The affected individual is then eligible to continue Coverage under COBRA Continuation Coverage, provided the individual enrolls and pays all contributions timely. Continuation of Coverage is subject to all COBRA Continuation Coverage rules and regulations.

An Employee with at least five years of health coverage participation in the Co-op Health & Welfare Plan, but less than 20 years of employment, who becomes disabled will have coverage for four months, which shall be concurrent with the Employer's leave policy. The Employer and Employee will share the contributions during this 4-month period. The affected individual is then eligible to continue Coverage under COBRA Continuation Coverage, provided the individual enrolls and pays all contributions timely. Continuation of Coverage is subject to all COBRA Continuation Coverage rules and regulations.

An Employee with at least five years of health coverage participation in the Co-op Health & Welfare Plan, and 20 years or more of employment, who becomes disabled will have coverage for four months, which shall be concurrent with the Employer's leave policy. The Employer and Employee will share the contributions during this 4-month period. The Employee can then apply for and pay the entire contribution for Coverage for up to eight months. This 8-month period is not considered COBRA Continuation Coverage. After this 8-month period, the affected individual is then eligible to continue Coverage under COBRA Continuation Coverage, provided the individual enrolls and pays all contributions timely. Continuation of Coverage is subject to all COBRA Continuation Coverage rules and regulations.

**F. Coverage For Medically Retired Persons**

An Employee with a minimum of 20 consecutive years of service with the Employer who becomes Disabled as defined by this Plan and has participated in the health coverage through the Co-op Health & Welfare Plan for five consecutive years (60 consecutive months) at the time Disability starts:

1. will be eligible for a maximum of four months of continued health Coverage from the date of Disability (see information regarding Family and Medical Leave.) This 4-month period may be less if Your Employer has a written leave of absence policy that is less than four months. The individual termination date will be at the end of the month in which Coverage terminates. The Employer will pay its usual contribution for this maximum 4-month period or until such time as Coverage is terminated, whichever is less;
2. will be eligible to continue to participate in the health Coverage provided Disability, as defined by the Plan document, continues and the individual enrolls and pays the entire cost of the contribution monthly for an additional eight months (non-COBRA.)

At the end of this 12 months, or if earlier, Disability ceases and the individual does not return to work, group Coverage for the individual is terminated and the Medically Retired person becomes eligible for COBRA Continuation Coverage. COBRA Continuation Coverage may continue for 18-29 additional months, depending upon their classification of Disability as defined by the Social Security Administration, provided the individual is properly enrolled in COBRA Continuation Coverage and pays all the contributions timely. Continuation of Coverage is subject to all COBRA Continuation Coverage rules and regulations. Refer to the COBRA Continuation Coverage section of the Plan document for complete details or contact the Employee Benefits Department division of Tennessee Farmers Cooperative for assistance. This provision is effective with respect to those whose Disability began on or after July 1, 2002.

Coverage for a Medically Retired person will in any event cease upon attainment of age 65, if that occurs before the period of Coverage would otherwise expire under the rules above.

Dependents will have access to Coverage through COBRA Continuation Coverage whether or not the Employee elects to keep the COBRA Continuation Coverage plan.

**G. Family and Medical Leave**

The provisions of the Plan shall meet the minimum requirements of the Family and Medical Leave Act of 1993 (FMLA) insofar as

an Employer is subject to such Act. For purposes of this Plan, the date Disability starts will be considered to be at the conclusion of any Paid Time Off (PTO) period or sick leave, etc., whenever an Employee chooses to use the accumulated time, provided the Employer allows this option. If the Employer does not choose to start FMLA after PTO or sick leave, etc., FMLA will run concurrent with any leave period.

**H. Seasonal Layoff**

As happens from time to time, when the Employer requires a seasonal lay-off due to employment conditions, Coverage may continue with normal contributions to the Plan up to a maximum of four months per occurrence per year.

**I. Leave of Absence**

Coverage may continue as prescribed by law or Employer policy for non-medical related requests if certain qualifications are met. The maximum coverage period under this provision will not exceed that previously detailed for medical disabilities, and leave types may not be stacked to extend the total length of coverage time allowable.

## ENROLLMENT

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

### A. Initial Enrollment Period

Eligible Employees may enroll for Coverage for themselves and their eligible dependents within the first 31 days after becoming eligible for Coverage. The Subscriber must: (1) include all requested information; (2) sign; and (3) submit an enrollment form to Employee Benefits Department during that initial enrollment period.

### B. Open Enrollment Period

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

### C. Adding Dependents

A Subscriber may add a dependent, who became eligible after the Subscriber enrolled, as follows:

1. A newborn child of the Subscriber or the Subscriber's spouse is Covered from the moment of birth. A legally adopted child, including children placed with You for the purpose of adoption, will be Covered as of the date of adoption or placement for adoption. Children for whom the Subscriber or the Subscriber's spouse has been appointed legal guardian by a court of competent jurisdiction, will be Covered from the moment the child is placed in the Subscriber's physical custody. The Subscriber must enroll that child within 31 days of the date that the Subscriber acquires the child.

   If the Subscriber fails to do so, and an additional Payment is required to cover a newborn or newly acquired child, the Plan will not provide Coverage for that child after 31 days. If no additional Payment is required to provide Coverage to the child, the Subscriber's failure to enroll the child does not make the child ineligible for Coverage.

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

2. If the legally adopted (or placed) child has Coverage of his or her medical expenses from a public or private agency or entity, the Subscriber may not add the child until that coverage ends. Any other new dependent, (e.g., if the Subscriber marries) may be added as a Covered Dependent if the Subscriber completes and submits a signed Enrollment Form to Employee Benefits Department within 31 days of the date that person first becomes eligible for Coverage.

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

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

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

      (1) such other coverage is: COBRA and the COBRA coverage is exhausted; or

      (2) Non-COBRA and

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

         (b) Employer contributions for the other coverage ended; and

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

### D. Late Enrollment

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

1. During a subsequent Open Enrollment Period; or

2. If the Employee acquires a new dependent, and he or she applies for Coverage within 31 days.

**E. Enrollment upon Change in Status**

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

## EFFECTIVE DATE OF COVERAGE

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

**A. Effective Date of ASA**

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

**B. Enrollment During an Open Enrollment Period**

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

**C. Enrollment During an Initial Enrollment Period**

Coverage shall be effective on the day of the month indicated on the Employee's Enrollment Form, following Employee Benefits Department's receipt of the Employee's Enrollment Form; or

**D. Newly Eligible Employees**

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

**E. Enrollment of Newly Eligible Dependents**

(1) Dependents acquired as the result of Employee's marriage – Coverage will be effective the first day of the month following the date the administrator receives the completed enrollment form, unless otherwise agreed to by the Trust and the administrator;

(2) Newborn children of the Employee or the Employee's spouse – Coverage will be effective as of the date of birth;

(3) Dependents adopted or placed for adoption with Employee – Coverage will be effective as of the date of adoption or placement for adoption, whichever is first.

For Coverage to be effective, the dependent must be enrolled, and the administrator must receive any required payment for the Coverage, as set out in the "Enrollment" section; or

**F. Actively at Work Rule**

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

## TERMINATION OF COVERAGE

### A. Termination or Modification of Coverage by BlueCross or the Trust

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

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

### B. Termination of Coverage Due to Loss of Eligibility

Your Coverage will terminate if You do not continue to meet the eligibility requirements agreed to by the Trust and the administrator during the term of the ASA. Coverage for a Member who has lost his/her eligibility shall automatically terminate at 12:00 midnight on the last day of the month during which that loss of eligibility occurred.

### C. Termination or Rescission of Coverage

The Plan may terminate Your Coverage for cause, if:

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

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.

### D. Right to Request a Hearing

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

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

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

### F. Extended Benefits

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

## SUBROGATION AND RIGHT OF REIMBURSEMENT

### A. Subrogation Rights

The Plan shall be subrogated to and/or have the right to recover amounts paid to provide Covered Services to You for illnesses or injuries caused, insured or reimbursed by any parties, including the right to recover the reasonable value of 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 affected by any reductions due to 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 supersedes any right that You or Your estate may have to be "made whole". In other words, the Plan is entitled to the right of first reimbursement out of any recovery You or Your estate might procure regardless of whether You or Your estate have received compensation for any of Your damages or expenses, including Your or Your estate's attorneys' fees or costs. This priority right of reimbursement supersedes Your or Your estate's right to be made whole from any recovery, whether full or partial. In addition, You agree on behalf of Yourself and Your estate 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 on behalf of Yourself and Your estate 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 or their estate);
- Any auto or recreational vehicle insurance coverage or benefits including, but not limited to, uninsured or underinsured 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 or Your estate incur.

<u>Notice and Cooperation</u>

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

The Plan may enforce its rights of subrogation and reimbursement against, without limitation, any tortfeasors, any responsible 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.

If You settle any claim or action against any 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 subrogation and recovery rights from the settlement fund. You shall hold any such proceeds of settlement or judgment in trust for the exclusive 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.

You agree that the proceeds subject to the Plan's lien are Plan assets and You and/or the executor or administrator of Your estate will hold such assets as a trustee for the Plan's benefit and shall remit to the Plan, or its representative, such assets upon request. If represented by counsel, You agree that You and/or the executor or administrator of Your estate will 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 You and/or the executor or administrator of Your estate 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.

## INTER-PLAN ARRANGEMENTS

### 1. 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 nonparticipating 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. Payments for out-of-network emergency services, certain services provided by out-of-network providers at in-network facilities, and out-of-network air ambulance services will be governed by applicable federal and state law.

**E. Blue Cross Blue Shield Global® Core**

If You are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard

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

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

- **Inpatient Services**

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

- **Outpatient Services**

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

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

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

## CLAIMS AND PAYMENT

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

**A. Claims.**

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

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

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

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

**B. Claims Billing.**

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

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

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

   b. To be reimbursed, You must submit the claim within 12 months from the date a Covered Service was received. If You do not submit a claim, within the 12 month time period, it will not be paid. If it is not reasonably possible to submit the claim within the 12 month time period, the claim will not be invalidated or reduced.

3. Not all Covered Services are available from Network Providers. There may be some Provider types that We do not contract with. These Providers are called Non-Contracted Providers. Claims for services received from Non-Contracted Providers are handled as described in section 2.a.and 2.b. above for Out-of-Network Providers. 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 also have the same responsibilities as described above.

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

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

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

   b. You may request a claim form from Our customer service department. We will

send You a claim form within 15 days. We may request additional information or documentation if it is reasonably necessary to make a Coverage decision concerning a claim.

**C. Payment.**

1. If You received Covered Services from a Network Provider, the Plan will pay the Network Provider directly. You authorize assignment of benefits to that Network Provider. If You have paid that Provider for the same claim, You must request a refund from that Provider. Covered Services will be paid at the In-Network Benefit level.

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

3. If the ASA is terminated, all claims for Covered Services rendered prior to the termination date, must be submitted to the Plan within 12 months from the date the Covered Services were received.

4. Benefits will be paid according to the Plan within 30 days after we receive a claim form that is complete. Claims are processed in accordance with current industry standards, and based on Our information at the time We receive the claim form. Neither the Plan nor We are responsible for over or under payment of claims if Our information is not complete or is inaccurate. We will make reasonable efforts to obtain and verify relevant facts when claim forms are submitted.

5. When a claim is paid or denied, in whole or part, We will produce a Claim Summary, sometimes referred to as an Explanation of Benefits (EOB). The Claim Summary will describe how much was paid to the Provider, and any amounts You owe to that Provider. The administrator will make the Claim Summary available to You at bcbst.com, or You can obtain it at no cost by calling the customer service department at the number listed on Your membership ID card.

6. You are responsible for paying any applicable Copayments, Coinsurance, or Deductible amounts to the Provider. If We pay such amounts to a healthcare provider on Your behalf, We may collect those cost-sharing amounts directly from You.

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

**D. Complete Information.**

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

Mail all claim forms to:

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

## 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 Utilization 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 admission and Emergency 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 Advanced Radiological Imaging services
- Certain Prosthetics
- Certain Orthotics
- Certain Durable Medical Equipment (DME)
- Certain Behavioral Health Services.

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 for low-risk health conditions, behavioral health conditions, substance use disorders and/or certain complicated medical or behavioral health needs.

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

Coverage matters, and help You and Your family utilize available community resources.

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

In that event, We may elect to offer alternative benefits for services not otherwise specified as Covered Services in Attachment A. 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 that program are Covered, even though they may normally be excluded under this EOC.

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

## C. Medical Policy

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

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

Medical policies state whether a Technology is Medically Necessary, Investigational or cosmetic. As technologies change and improve, and as Members' needs change, We may reevaluate and change medical policies without formal notice. Visit bcbst.com/mpm to review Our medical policies.

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

## 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.

## HEALTH AND WELLNESS SERVICES

The Plan provides You with resources to help improve and manage Your health. To learn more about these resources or any changes to Your resources, log in at bcbst.com 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.

**Digital Self-Guided Health Programs** – Our interactive and educational digital self-guided programs help to inform You about common health and wellness 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. For more information, log in at bcbst.com.

**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 as well as live and recorded virtual fitness classes. You also have access to discounts for complementary and alternative medicine services.

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

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

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

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

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

## CONTINUATION OF COVERAGE

### Federal Law

If the ASA remains in effect, but Your Coverage under this EOC would otherwise terminate, the Trust 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.

   b. 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.

2. Enrolling for COBRA Continuation Coverage

   Employee Benefits Department, acting on behalf of the Trust, shall notify You of Your rights to enroll for COBRA Continuation Coverage after:

   a. The Subscriber's termination of employment, reduction in hours worked, death or entitlement to Medicare coverage; or

   b. The Subscriber or Covered Dependent notifies the Employer, in writing, within 60 days after any other qualifying event set out above.

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

3. Payment

   You must submit any Payment required for COBRA Continuation Coverage to Employee Benefits Department 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 Trust (or to Employee Benefits Department, if so directed by the Trust) within 45 days after the date You enroll for COBRA Continuation Coverage. After enrolling for COBRA Continuation Coverage, all Payments are due and payable on a monthly basis as required by the Trust. If the Payment is not received by Employee Benefits Department 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. Employee Benefits Department may use a third party vendor to collect the COBRA Payment.

4. 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 Trust may agree to change the ASA and/or this EOC. The Trust may also decide to change administrators. If this happens after You enroll for COBRA Continuation Coverage, Your Coverage will be subject to such changes.

5. Duration of Eligibility for COBRA Continuation Coverage

   COBRA Continuation Coverage is available for a maximum of:

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

   b. 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. It does not matter when the disability began, so long as You are disabled within the first 60 days of COBRA Continuation Coverage. 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

   c. 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

   d. 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.

6. 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:

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

   b. 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

   c. The ASA is terminated; or

   d. You become entitled to Medicare Coverage; or

   e. The date that You or Your Covered Dependents, otherwise eligible for 29 months of COBRA Continuation Coverage, are determined to no longer be disabled for purposes of the COBRA law.

7. 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.

8. 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.

9. 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.

## COORDINATION OF BENEFITS

### A. Purpose of Coordination of Benefits

If another Payor provides coverage to You, the Plan may coordinate its benefits with those of that other Payor (the "Primary Plan"). The Plan will follow the "Maintenance of Benefits" alternative to coordinate benefits when it is the secondary Plan.

When the Plan is secondary (meaning it determines its benefits after another Plan), its benefits plus those of the Primary Plan will be less than 100% of Allowable Expenses unless the Primary Plan, by itself, provides benefits at 100% of Allowable Expenses.

### B. Information About Coverage From Other Payors

Information about Your Coverage by other Payors, which is set forth on the enrollment form, is material information. A Subscriber must submit a completed change form if there is any change in the Subscriber's Coverage or a Covered Dependent's Coverage by other Payors during the term of Coverage by the Plan. You must cooperate, upon reasonable request, to permit the Plan to coordinate its Coverage with that provided by other Payors.

### C. Group Coordination of Benefits

The Plan shall coordinate benefits as follows:

1. Applicability

   a. This coordination of benefits (COB) provision applies when You have health care coverage under more than one plan.

   b. If this COB provision applies, the order of benefit determination rules are applied. Those rules determine whether the Plan's benefits are determined before or after those of another plan. The Plan's benefits:

      (1) Shall not be reduced when, under the order of benefit determination rules, the Plan determines its benefits before another plan (i.e. is the Primary Plan); but

      (2) May be reduced when, under the order of benefits determination rules, another plan determines its benefits first. This reduction is described in subdivision d below, "Effect on the Benefits of This Plan."

2. Definition of Terms Used in this Section

   a. A "**Plan**" provides benefits or services for medical or dental care or treatment, from:

      (1) Group insurance or group-type coverage, whether insured or uninsured. This includes health maintenance, prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

      (2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state Medicaid Plan (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act).

   b. Primary Plan and Secondary Plan. The order of benefit determination rules state whether this Plan is a Primary Plan or secondary Plan as to another Plan covering the person. When this Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits. 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. When there are more than 2 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(s).

   c. Allowable Expense means a necessary, reasonable and customary item of expense for health care, when that expense is Covered at least in part by one or more Plans covering the person for whom the claim is made. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid. When benefits are reduced under a Primary Plan because a Covered person does not comply with the Plan provisions, the amount of that reduction will not be considered an Allowable Expense.

   d. Claim Determination Period means a Calendar Year. However, it does not include any part of a year during which a person has no Coverage under this Plan.

3. Order of Benefit Determination Rules

a. General. When there is a basis for a claim under this Plan and another Plan, this Plan is a secondary Plan, which determines its benefits after those of the other Plan, unless:

(1) The other Plan has rules coordinating its benefits with those of this Plan; and

(2) Both those rules and this Plan's rules, set forth below, require that this Plan's benefits be determined before those of the other Plan.

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

(1) Nondependent/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;

(2) Dependent child/parents not separated or divorced. Except as stated in paragraph 3(b) 3, when this Plan and another Plan cover the same child as a dependent of different parents:

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

(b) If both parents have the same birthday, the benefits of the Plan that Covered one parent longer are determined before those of the Plans that Covered the other parent for a shorter period of time. However, if the other Plan does not have the rule described previously in 3(b)(2)(a) or (b) and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

(3) Dependent child/separated or divorced. If 2 or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

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

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

(c) Finally, the Plan of the parent not having custody of the child. However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the Plan that is obligated to pay or provide benefits to that child under that decree has actual knowledge of those terms, the benefits of that Plan are determined first.

(4) Joint custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that 1of 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 3(b)(2).

(5) 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 that covers that person as a laid off or retired Employee. The same would be true if a person is a dependent of a person Covered as a retiree and an 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 (5) is ignored.

(6) Longer/shorter length of Coverage. If none of the previous rules determines the order of benefits, the benefits of the Plan that Covered an Employee, Member or Subscriber for the longer period are determined before those of the Plan covering that person for the shorter period.

4. Effect On the Benefits Of This Plan

a. When This Section Applies. This section 4 applies when, in accordance with the Order of Benefit Determination Rules, this Plan is a secondary Plan as to 1or

more other Plans (the "Other Plans"). In that event, the benefits of this Plan may be reduced under this section.

b. Reduction in this Plan's benefits.

(1) The benefits that would be payable for the allowable expenses under this Plan in the absence of this COB provision will be reduced by the benefits payable under the other Plans for the expenses Covered in whole or in part under this Plan. This applies whether or not claim is made under a Plan.

(2) When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both the expense incurred and the benefit payable.

(3) When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

5. Right To Receive And Release Needed Information

Certain facts are needed to apply these COB rules. The Plan has the right to decide which facts it needs. It may get needed facts from or give information to any other organization or person. The Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give the Plan any facts it needs to pay the claim.

6. Facility of Payment

A payment made under Other Plans may include an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the Other Plan that made that payment. That amount will then be treated as though it were a benefit paid under this Plan, which 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.

7. 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 person it has paid or for whom it has made such payment;

b. Other plans; or

c. Other organizations.

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

**D. Subscribers and Covered Dependents Enrolled for Medicare**

The Plan will follow applicable Medicare statutes and regulations to determine if it or Medicare should be the Primary Plan for Covered Services rendered to You when You are also eligible for Medicare Coverage. The Plan will provide You with a summary of those statutes and regulations upon request.

## GRIEVANCE PROCEDURE

### I. INTRODUCTION

Our Grievance Procedure (the "Procedure") is intended to provide a fair, quick and inexpensive method of resolving any and all Disputes with the Plan. Such Disputes include: any matters that cause You to be dissatisfied with any aspect of Your relationship with the Plan; any Adverse Benefit Determination concerning a claim; or any other claim, controversy, or potential cause of action You may have against the Plan. Please contact Our consumer advisors at the number on the back of Your ID card: (1) to file a claim; (2) if You have any questions about this EOC or other documents related to Your Coverage (e.g., a Claim Summary, sometimes referred to as an Explanation of Benefits or Monthly Claims Statement); or (3) to initiate a Grievance concerning a Dispute.

1. This Grievance 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 Grievance Procedure can only resolve Disputes that are subject to Our control.
3. You cannot use this Grievance Procedure to resolve a claim that a Provider was negligent. Network Providers are independent contractors. They are solely responsible for making treatment decisions in consultation with their patients. You may contact 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. The Plan and You may agree to skip one or more of the steps of this Grievance Procedure if it will not help to resolve 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 Our consumer advisors 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 Our consumer advisors at the number on the back of Your 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) A statement of the committee's understanding of Your Grievance;

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

(c) 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 Grievance 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 or Rescissions**

If Your Grievance involves a Medical Necessity determination, or grievances with respect to

Emergency Care Services rendered at an out-of-network hospital, items and services rendered by an Out-of-Network Provider at an in-network hospital (unless You agreed with the Provider prior to the services to accept out-of-network terms under regulatory requirements) and Authorized air ambulance services, then either: (1) after completion of the mandatory first level Grievance; or (2) after completion of the mandatory first level Grievance followed by completion of the 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 Trust or the Trust's Plan, until the independent reviewer makes its decision.

The Trust or the Trust'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

## DEFINITIONS

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

1. **Actively At Work** – The performance of all of an Employee's regular duties for the Employer on a regularly scheduled workday at the location where such duties are normally performed. Eligible Employees will be considered to be Actively At Work on a non-scheduled work day (which would include a scheduled vacation day) only if the Employee was Actively At Work on the last regularly scheduled work day.
2. **Acute** – An illness or injury which is both severe and of short duration.
3. **Administrative Services Agreement or ASA** – The arrangements between the administrator and the Trust, including any amendments, and any attachments to the ASA or this EOC.
4. **Advanced Radiological Imaging** – Services such as MRIs, CT scans, PET scans, nuclear medicine and similar technologies.
5. **Adverse Benefit Determination** – Any denial, reduction, termination or failure to provide or make payment for what You believe should be a Covered Service. Adverse Benefit Determinations include:
    a. A determination by a health carrier or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health carrier's health benefit plan does not meet the health carrier's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit;
    b. The denial, Rescission, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier of a Covered person's eligibility to participate in the health carrier's health benefit plan; or
    c. Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment for, in whole or in part, a benefit.
6. **Annual Benefit Period** – The 12-month period under which Your benefits are administered, as noted in Attachment C: Schedule of Benefits.
7. **Behavioral Health Services** – Any services or supplies that are Medically Necessary and Medically Appropriate to treat: a mental or nervous condition; alcoholism; chemical dependence; drug abuse or drug addiction.
8. **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.
9. **Blue Distinction Centers for Transplants (BDCT) Network –** A network of facilities and hospitals contracted with BlueCross (or with an entity on behalf of BlueCross) to provide Transplant Services for some or all organ and bone marrow/stem cell transplant procedures Covered under this EOC, 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/stem cell transplant procedure but not for another type of transplant. This designation is important as it impacts the level of benefit You will receive.
10. **BlueCard PPO Participating Provider** – A physician, Hospital, licensed skilled nursing facility, home health care provider or other Provider who contracts with other BlueCross and/or BlueShield Association, (BlueCard PPO) Plans and/or whom the Plan has Authorized to provide Covered Services to Members.
11. **Calendar Year** – The period of time beginning at 12:01 A.M. on January 1st and ending 12:00 A.M. on December 31st.
12. **Care Management** –Programs that promote cost effective coordination of care for Members with low-risk health conditions, behavioral health conditions, substance use disorders and/or certain complicated medical or behavioral health needs.
13. **CHIP** – The State Children's Health Insurance Program established under title XXI of the Social Security Act (42 U.S.C. 1396 et. seq.)
14. **Coinsurance** – The amount, stated as a percentage of the Maximum Allowable Charge for a Covered Service that is the Member's responsibility during the Annual Benefit Period after any Deductible is satisfied. The Coinsurance percentage is calculated as 100%,

minus the percentage Payment of the Maximum Allowable Charge as specified in Attachment C: Schedule of Benefits.

In addition to the Coinsurance percentage, You are responsible for the difference between the Billed Charges and the Maximum Allowable Charge for Covered Services if the Billed Charges of a Non-Contracted Provider or an Out-of-Network Provider are more than the Maximum Allowable Charge for such Services.

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

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

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

17. **Convenience or Convenience Item(s)** – Any service, item, device, software or equipment that is related primarily to the ease or preference of the Member, family, caregiver or Provider rather than to Medical Necessity of care.

18. **Copayment** – The dollar amount specified in Attachment C, Schedule of Benefits, that You are required to pay directly to a Provider for certain Covered Services. You must pay such Copayments at the time You receive those Services.

19. **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.

20. **Covered Dependent** – A Subscriber's family member who: (1) meets the eligibility requirements of this EOC; (2) has been enrolled for Coverage; and (3) for whom the Plan has received the applicable Payment for Coverage.

21. **Covered Family Members** – A Subscriber and his or her Covered Dependents.

22. **Covered Services, Coverage or Covered** – Those Medically Necessary and Medically Appropriate services and supplies that are set forth in Attachment A of this EOC, (which is incorporated by reference). Covered Services are subject to all the terms, conditions, exclusions and limitations of the Plan and this EOC. Covered Services shall not include items or services that are illegal or unlawful when furnished by the Provider.

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

24. **Deductible** – The dollar amount specified in Attachment C, Schedule of Benefits that You must incur and pay for Covered Services during an Annual Benefit Period before the Plan provides benefits for services. There are 2 separate Deductible amounts – one for Network Providers and one for Out-of-Network Providers. Satisfying the Deductible under the Network Provider benefits does not satisfy the Deductible for the Out-of-Network Provider benefits, and vice versa. The Deductible will apply to the Individual Out-of-Pocket and Family Out-of-Pocket Maximum(s).

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

    There are 2 categories of Deductible, Self-Only and Family. Covered Dependents do not have a separate Deductible. See Family Deductible.

    a. **Family Deductible** - The dollar amount specified in Attachment C: Schedule of Benefits that a Subscriber and Covered Dependents must incur and pay for Covered Services during an Annual Benefit Period before the Plan provides benefits for such Services. The full Family Deductible must

be satisfied before benefits will be paid for the Subscriber or any Covered Dependents.

Once the Network Family Deductible amount has been satisfied by one or more Covered Family Members during an Annual Benefit Period, the Network Family Deductible will be considered satisfied for all Covered Family Members for the remainder of that Annual Benefit Period.

Once the Out-of-Network Family Deductible amount has been satisfied, by one or more Covered Family Members during an Annual Benefit Period, the Out-of-Network Family Deductible will be considered satisfied for all Covered Family Members for the remainder of that Annual Benefit Period.

The Network Family Deductible will apply to the Network Family Out-of-Pocket Maximum, and the Out-of-Network Family Deductible, will apply to the Out-of-Network Family Out-of-Pocket Maximum.

b. **Self-Only Deductible** – The dollar amount specified in Attachment C: Schedule of Benefits that a Subscriber with Self-Only Coverage must incur and pay for Covered Services during an Annual Benefit Period before the Plan provides benefits for services.

Once the Network Self-Only Deductible amount has been satisfied by the Subscriber with Self-Only Coverage during an Annual Benefit Period, the Network Self-Only Deductible will be considered satisfied for the remainder of that Annual Benefit Period.

Once the Out-of-Network Self-Only Deductible amount has been satisfied, by the Subscriber with Self-Only Coverage during an Annual Benefit Period, the Out-of-Network Self-Only Deductible will be considered satisfied for the remainder of that Annual Benefit Period.

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

25. **Disabled, Disability** – A physical state of a Covered person resulting from an illness or injury that:

    a. in the case of an Employee, wholly prevents him or her from engaging in the duties of his or her normal occupation;

    b. in the case of a Dependent or a COBRA beneficiary, wholly prevents him or her from performing the normal activities of a person for that age and sex in good health and in similar circumstances.

    Disability means that the Employee is prevented by illness or injury from performing one or more of the essential duties of the occupation in which the Employee was engaged at the time of the Disability.

    As a result of such Disability, the Employee has monthly earnings of no more than 80% of the Employee's indexed pre-Disability earnings. Indexed pre-Disability earnings will be determined in accordance with the Plan's long term Disability benefit as in effect at the onset of the Disability (without regard to whether the Employee is covered by such benefit.)

    In the case of an illness due to drug, alcohol or substance abuse or dependency, the period of coverage may not exceed the earlier of the date of successful completion of an approved rehabilitation program, or the date the Employee ceases or refuses to participate in the rehabilitation program.

    The Plan reserves the right to have any Employee claiming such Disability to be examined by an independent medical examiner whenever and as often as needed to determine the validity of such claim.

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

    a. serious impairment of bodily functions; or

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

    c. placing a prudent layperson's health in serious jeopardy.

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

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

freestanding emergency department. Emergency Care Services may include items and services after the Member is stabilized and as part of outpatient observation or an inpatient or outpatient stay related to the Emergency.

28. **Employee** – A person who fulfills all eligibility requirements established by the Employer and the administrator.

29. **Employer** – A corporation, partnership, union or other entity that is eligible for group coverage under State and Federal laws.

30. **Enrollment Form** – A form or application that must be completed in full by the eligible Employee before he or she will be considered for Coverage under the Plan. The form or application may be in paper form, or electronic, as determined by the Plan Sponsor.

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

32. **Family Coverage** – Coverage for the Subscriber and one or more Covered Dependents.

33. **Hearing Aid(s)** – An instrument to amplify sounds for those with hearing loss. There are 2 types of Hearing Aids: the air conduction type, which is worn in the external acoustic meatus, and the bone conduction type, which is worn in the back of the ear over the mastoid process. Examples of Hearing Aids that would fall within this definition are the Baha® system and the Otomag™ Hearing System. Cochlear implants are a prosthetic and are not considered Hearing Aids.

34. **Hospital** – A facility that:

    a. Operates pursuant to law;

    b. Provides 24-hour nursing services by a registered nurse (RN) on duty or call;

    c. Has a staff of one or more Physicians at all times; and

    d. Provides organized facilities and equipment for diagnosis and treatment of Acute medical, surgical or mental/nervous conditions either on its premises or in facilities available to it on a pre-arranged basis.

    Hospital does not include: Residential or nonresidential treatment facilities; health resorts; nursing homes; Christian Science sanatoria; institutions for exceptional children; Skilled Nursing Facilities; places that are primarily for the care of convalescents; clinics; Physician's offices; private homes; Ambulatory Surgical Centers and Hospices.

35. **Hospital Confinement or Hospital Admission** – When You are treated as a registered bed patient at a Hospital or other Provider facility and incur a room and board charge.

36. **Hospital Services** – Covered Services that are Medically Appropriate to be provided by an Acute care Hospital.

37. **Incapacitated Child** – An unmarried child of the Subscriber who is Covered under the Plan upon reaching the Plan's Limiting Age, and continues to be, both (1) incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition; and (2) chiefly dependent upon the Subscriber or Subscriber's Covered spouse for economic support and maintenance.

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

    b. Incapacitated dependents of Subscribers of new groups, or of Subscribers who are newly eligible under this Plan, are eligible for Coverage if they were Covered under the Subscriber's or the Subscriber's Covered spouse's previous health benefit plan. Proof of the incapacity and dependency upon enrollment. Annual proof of the dependent's continued compliance with the terms of incapacity and dependency may be required.

38. **In-Network Benefit** – The Plan's payment level that applies to Covered Services received from a Network Provider. See Attachment C, Schedule of Benefits.

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

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

        i. This criterion applies to drugs, biological products, devices and any other product or procedure that must have final approval to market from the

U.S. Food and Drug Administration or any other federal governmental body with authority to regulate the use of the Technology.

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

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

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

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

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

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

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

i. 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.

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

a. Your medical records, or

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

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

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

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

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

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

40. **Late Enrollee** – An Employee or eligible Dependent who fails to apply for Coverage within 31 days after such person first became eligible for Coverage under this EOC.

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

42. **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 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.

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

44. **Medical Director** – The Physician designated by the administrator, or that Physician's designee, who is responsible for the administration of the administrator's medical management programs, including its Authorization/Prior Authorization programs.

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

    a. be Medically Necessary;

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

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

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

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

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

    - 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. The definition of "Medically Necessary or Medical Necessity" applies to both medical services and Behavioral Health Services.

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

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

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

50. **Member Payment** – The dollar amounts for Covered Services that the Member is responsible for as set forth in Attachment C, Schedule of Benefits, including Copayments, Deductibles, Coinsurance and Penalties.

51. **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 BlueCard PPO Participating Providers, participating hospitals, In-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.

52. **Non-Contracted Provider** – A Provider that renders Covered Services to a Member, in the situation where We have not contracted with that Provider 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.

53. **Non-Routine Diagnostic Services** – Services listed under Non-Routine Diagnostic Services in Attachment A, Covered Services.

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

55. **Out-of-Network Provider** – Any Provider who is an eligible Provider type but who does not hold a contract with the administrator to provide Covered Services.

56. **Out-of-Pocket Maximum** – The total dollar amount, as stated in Attachment C, Schedule of Benefits, that a Member must incur and pay for Covered Services during the Annual Benefit Period, including Deductible and Coinsurance. The Out-of-Pocket Maximum applies to Network Providers only.

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

    When the Out-of-Pocket Maximum is satisfied, 100% of available benefits is payable for other Covered Services incurred by the Member during the remainder of that Annual Benefit Period, excluding applicable Copayments and Penalties, and any balance of charges (the difference between Billed Charges and the Maximum Allowable Amount).

    There are two 2 categories of Out-of-Pocket Maximum, Self-Only and Family.

    a. **Family Out-of-Pocket Maximum** – The total dollar amount, as stated in the Schedule of Benefits: Attachment C that a Subscriber and his or her Covered Dependents must incur and pay for Covered Services during the Annual Benefit Period, including Deductible and Coinsurance.

       When the Network Family Out-of-Pocket Maximum is satisfied, benefits are payable at 100% for other Covered Services from Network Providers for all Covered Family Members during the remainder of that Annual Benefit Period, excluding applicable Copayments and Penalties, any balance of charges (between Billed Charges and the Maximum Allowable Charge), and benefits exceeding the Lifetime Maximum.

       When the Out-of-Network Family Out-of-Pocket Maximum is satisfied, benefits are payable at 100% for other Covered Services from Out-of-Network Providers for all Covered Family Members during the remainder of that Annual Benefit Period, excluding applicable Penalties, any balance of charges, (the difference between Billed Charges and Maximum Allowable Charge), and benefits exceeding the Lifetime Maximum.

       The full Family Out-of-Pocket Maximum must be satisfied before benefits are paid at 100% for any Covered Family Member.

    b. **Self-Only Out-of-Pocket Maximum** – The total dollar amount, as stated in Attachment C: Schedule of Benefits, which a Subscriber with Self-Only Coverage must incur and pay for Covered Services during the Annual Benefit Period, including Deductible and Coinsurance.

       When the Network Self-Only Out-of-Pocket Maximum is satisfied, benefits are payable at 100% for other Covered Services from Network Providers for the Subscriber with Self-Only Coverage during the remainder of that Annual Benefit Period, excluding applicable Penalties, any balance of charges (between Billed Charges and the Maximum Allowable Charge), and benefits exceeding the Lifetime Maximum.

       When the Out-of-Network Self-Only Out-of-Pocket Maximum is satisfied, benefits are payable at 100% for other Covered Services from Out-of-Network Providers for the Subscriber with Self-Only Coverage during the remainder of that Annual Benefit Period, excluding applicable Penalties, any balance of charges, (the difference between Billed Charges and Maximum Allowable Charge), and benefits exceeding the Lifetime Maximum.

57. **Payment** – The total payment for Coverage under the Plan, including amounts paid by You and the Trust for such Coverage.

58. **Payor(s)** – An insurer, health maintenance organization, no-fault liability insurer, self-insurer or other entity that provides or pays for a Member's health care benefits.

59. **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 Maximum.

60. **Periodic Health Screening** – An assessment of patient's health status at intervals set forth in the administrator's Medical Policy for the purpose of maintaining health and detecting disease in its early state. This assessment should include:

    a. a complete history or interval update of the patient's history and a review of systems; and

    b. a physical examination of all major organ systems, and preventive screening tests per the administrator's Medical Policy.

61. **Practitioner** – A person licensed by the State to provide medical or Behavioral Health Services.

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

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

64. **Qualified Medical Child Support Order** – A medical child support order, issued by a court of competent jurisdiction or a 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.

65. **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.

66. **Self-Only Coverage** – Coverage just for the Subscriber. It does not include any dependents.

67. **Subscriber** – An Employee who meets all applicable eligibility requirements, has enrolled for Coverage and who has submitted the applicable Payment for Coverage.

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

69. **Totally Disabled or Total Disability** – Either:

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

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

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

same as the Blue Distinction Centers for Transplants (BDCT) Network.

71. **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 of this EOC.

72. **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.

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

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

75. **Waiting Period** – The time that must pass before an Employee or Dependent is eligible to be Covered for benefits under the Plan.

76. **Well Child Care** – A routine visit to a pediatrician or other qualified Practitioner to include Medically Necessary and Medically Appropriate Periodic Health Screenings, immunizations and injections for children up to the age of 6 years.

77. **Well Woman Exam** – A routine visit every Annual Benefit Period to a Provider. The visit may include Medically Necessary and Medically Appropriate mammogram and cervical cancer screenings.

## ATTACHMENT A: COVERED SERVICES AND LIMITATIONS ON COVERED SERVICES

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

To be eligible for reimbursement or payment, all services or supplies must be provided in accordance with this EOC, applicable medical policies, third-party clinical guidelines adopted by BlueCross, and Utilization Policies. (See Prior Authorization, Care Management, Medical Policy and Patient Safety section.)

Covered Services and Limitations set forth in this Attachment are arranged according to:

- Eligible Providers, and
- Eligible services.

**An item or service, to be a Covered Service, must not be illegal or unlawful when rendered by the Provider.**

**An advantage of using PPO Network Providers is these Providers have agreed to accept the Maximum Allowable Charge set by the Plan for Covered Services. Network Providers have also agreed not to bill You for amounts above these amounts.**

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

**All services and supplies not listed in this EOC or not in accordance with applicable medical policies, third-party clinical guidelines adopted by BlueCross, and Utilization Policies may result in the denial of payment or a reduction in reimbursement for otherwise eligible Covered Services. The administrator's Utilization Policies can help Your Provider determine if a proposed service will be covered.**

## I. ELIGIBLE PROVIDERS OF SERVICE

### A. Practitioners

All services must be rendered by a Practitioner type listed in the administrator's Provider Directory of Network Providers, or as otherwise required by Tennessee law. The services provided by a Practitioner must be within his or her specialty or degree. All services must be rendered by the Practitioner, or the delegate actually billing for the Practitioner, and be within the scope of his or her licensure.

### B. Network Provider

A Provider who has contracted with the administrator to provide Covered Services.

### C. Non-Contracted Provider

A Provider that renders Covered Services to a Member but is in a specialty category or type with which We do not contract. A Non-Contracted Provider is not eligible to hold a contract with the administrator.

### D. Out-of-Network Provider

Any Provider who is an eligible Provider type but who does not hold a contract with the administrator to provide Covered Services.

### E. Other Providers of Service

An individual or facility, other than a Practitioner, duly licensed to provide Covered Services.

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

## II. ELIGIBLE SERVICES:

### A. Practitioner Office Services

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

1. Covered

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

   b. Second surgical opinions given by a Provider who is not in the same medical group as the Physician who initially recommended the surgery.

   c. Telehealth.

   d. Preventive/Well care services.

      Preventive health exam for adults and children in accordance with federal regulations, as outlined below and performed by the physician during the preventive health exam or referred by the physician as appropriate, including:

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

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

      (3) Preventive care and screening for women as provided in the guidelines supported by HRSA, and

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

2. Exclusions

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

   b. Rehabilitative therapies are subject to the limitations of the Therapeutic/ Rehabilitative benefit.

### B. Office Surgery

Medically Necessary and Medically Appropriate surgeries/procedures performed in a Practitioner's office. Surgeries involve an excision or incision of the body's skin or mucosal tissues, treatment of broken or dislocated bones, and/or insertion of instruments for exploratory or diagnostic purposes into a natural body opening.

1. Covered

   a. Excisions (including mole removal), incisions.

   b. Surgical repairs, including suturing lacerations.

   c. Biopsies.

   d. Endoscopies.

   e. Casting and splinting.

   f. Joint injection and drainage.

   g. Cryosurgery.

   h. Vasectomy.

2. Exclusions

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

   b. Some Covered procedures may require pre-certification (or Prior Authorization) and/or special consent, in accordance with the administrator's Medical Policy and procedures. Call the customer service department to find out which surgeries require Prior Authorization.

### C. Inpatient Acute Care Hospital Services

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

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

1. Covered

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

    b. Prescription Drugs that are prescribed, dispensed or intended for use while the Covered Person is confined in a hospital, skilled nursing facility or other similar facility.

    c. Attending Practitioner's services for professional care.

    d. Maternity and delivery services, including Complications of Pregnancy.

    e. Observation stays.

    f. Blood/plasma is Covered unless free.

2. Assistant Surgeon

    a. Benefits will be provided for surgery performed by a physician who actively assists the operating surgeon in the performance of a Covered surgical procedure, provided; (1) no intern, resident, or other staff physician is available; and (2) the administrator's Medical Policies and procedures recognize such procedure as requiring an assistant surgeon.

3. Exclusions

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

    b. Private duty nursing.

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

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

**D. <u>Emergency Care Services</u>**

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

If You go to a Network Provider, You will receive the highest level of benefits for Covered Services and may not be billed for amounts over Your Deductible and Out-of-Pocket Maximum, which limits Your liability. Not all Providers are in Your network. Please use the Provider directory on bcbst.com or contact one of Our consumer advisors to see which Providers are in Your network.

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

1. Covered

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

    b. Practitioner services.

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

2. Exclusions

    a. Once the Member's medical condition has stabilized, Prior Authorization must be obtained from the administrator for inpatient care or transfer to another facility. Benefits will be denied or reduced if such Authorization is not obtained within two business days from the inpatient admission.

**E. <u>Ambulance Services</u>**

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 Services

    a. Ambulance Services - Air

(1) Medically Necessary and Medically Appropriate air transportation from the scene of an accident or Emergency resulting in complex trauma, high risk injuries, or life-threatening medical emergencies to the nearest hospital with adequate facilities for evaluation and initial management. Air transportation is Covered only when Your condition requires immediate and rapid transport that cannot be provided by ground transport.

(2) Air transportation for inter-facility transfers when Medically Necessary treatment, services, or care are not available at the sending facility. The transfer must be to the nearest appropriate facility that is able to provide Medically Necessary care. Air transportation is Covered only when Your condition requires transport that cannot be provided by ground transport.

b. Ambulance Services - Ground

(1) Medically Necessary and Medically Appropriate ground transportation from the scene of an accident or Emergency to the nearest hospital with adequate facilities for evaluation and management.

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

(3) Medically Necessary and Medically Appropriate transport when Your condition requires basic or advanced life support, or safe transportation to site of service for the necessary level of care in the absence of appropriate alternatives.

2. Exclusions

a. Transportation for the Convenience of You, or reasons other than Medically Necessary treatment and care for You, such as the needs or Convenience of Your family and/or Your physician or other Provider.

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

c. Transportation for specific Provider or facility continuity of care when there are closer facilities able to provide the same services and level of care.

**F. Outpatient Facility Services**

Medically Necessary and Medically Appropriate diagnostics, therapies and surgery occurring in an outpatient facility which includes outpatient surgery centers, the outpatient center of a Hospital and outpatient diagnostic centers.

1. Covered

a. Practitioner services.

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

c. Outpatient treatments (such as medications and injections.)

d. Outpatient surgery and supplies.

e. Observation stays.

f. Telehealth.

2. Exclusions

a. Rehabilitative therapies are subject to the terms of the Therapeutic/ Rehabilitative benefit.

b. Services that could be provided in a less intensive setting.

c. Prior Authorization for certain outpatient surgeries must be obtained from the administrator or benefits will be denied or reduced. Call the customer service department to find out which surgeries require Prior Authorization.

**G. Family Planning and Reproductive Services**

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

1. Covered

a. Benefits for family planning, history, physical examination, diagnostic testing and genetic testing.

b. Sterilization procedures.

c. Medically Necessary and Medically Appropriate termination of a pregnancy.

d. Injectable and implantable contraceptives and vaginal barrier methods including initial fitting and insertion and removal.

2. Exclusions

   a. Benefits for any services or supplies that are designed to medically enhance a Member's level of fertility in the absence of a disease state.

   b. Assisted Reproductive Technology (ART), such as GIFT, ZIFT, in vitro fertilization and fertility drugs.

   c. Services or supplies for the reversals of sterilizations.

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

**H. Reconstructive Surgery**

Medically Necessary and Medically Appropriate surgical procedures intended to restore normal form or function.

1. Covered

   a. Surgery to correct significant defects from congenital causes, accidents or disfigurement from a disease state.

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

2. Exclusions

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

   b. Surgeries to correct or repair the results of a prior surgical procedure, the primary purpose of which was to improve appearance.

   c. Voice modification Surgery or voice therapy.

   d. Transportation, meals, lodging, or similar expenses.

   e. Surgeries and related services to change gender.

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

Medically Necessary and Medically Appropriate Inpatient care provided to patients requiring medical, rehabilitative or nursing care in a restorative setting. Services shall be considered separate and distinct from the levels of Acute care rendered in a Hospital setting, or custodial or functional care rendered in a nursing home.

1. Covered

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

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

   c. Coverage will be limited as shown in Attachment C, Schedule of Benefits.

   d. Therapy services such as physical and occupational therapy.

2. Exclusions

   a. Custodial Care, domiciliary or private duty nursing services.

   b. Skilled Nursing services not received in a Medicare certified skilled nursing facility.

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

   d) Inpatient neurocognitive therapy, unless it is provided in combination with other Medically Necessary treatment or therapy.

**J. Therapeutic/Rehabilitative Services**

Medically Necessary and Medically Appropriate therapeutic and rehabilitative services performed in a Practitioner's office, outpatient facility or home health setting and intended to restore or improve bodily function lost as the result of Acute illness, Acute injury, autism spectrum disorder or congenital anomaly.

Therapeutic/Rehabilitative services may require Prior Authorization. For Therapeutic/Rehabilitative services received in the home health setting, Home Health Care benefits will apply.

1. Covered

   a. Outpatient, home health or office therapeutic and rehabilitative services that are expected to result in significant and measurable improvement in Your condition resulting from an Acute illness, Acute injury, autism spectrum disorder, or congenital anomaly. The services must be performed by, or under the direct supervision of a licensed therapist.

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

      (1) Speech therapy is Covered only for disorders of articulation and swallowing, resulting from Acute illness, Acute injury, stroke, autism spectrum disorder, or congenital anomaly.

   c. Telehealth.

   d. Coverage is limited. See Attachment C, Schedule of Benefits.

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

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

2. Exclusions

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

   b. Complementary and alternative therapeutic services, including, but not limited to: (1) massage therapy; (2) acupuncture; (3) craniosacral therapy; and (4) vision exercise therapy.

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

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

**K. <u>Organ Transplants – 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. Benefits for Transplant Services that have not received Prior Authorization will be reduced or denied.

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 Transplant Case Management 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. **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. **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.

3. Covered Services

Benefits are payable for the following transplants if Medical Necessity and Medically Appropriate is determined 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, in Our discretion, 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 Transplant Case Management 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.

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

:

- Lodging expenses are limited to $50 per person per day
- Meals are only Covered when provided at the facility where You are receiving inpatient medical care.
- 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 Acute Care Hospital Service or Outpatient Facility Service, if Medically Necessary.

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

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

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

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

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

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

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

iii. 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 for the organ donor as a result of kidney donation.

## M. Dental Services, TMJ, and Oral Surgical Treatment

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

1. Covered

a. Dental services and oral surgical care to treat head and neck cancer, or to treat accidental injury to the jaw, natural teeth, mouth, or face, due to external trauma. The surgery and services to treat accidental injury must be started within 3 months and completed within 12 months of the accident.

b. Oral surgical care resulting from disease of the jaw, natural teeth, mouth or face, including cancer, tumors or bone cysts, which require pathological examination of the maxilla or mandible.

c. Surgery and services to correct congenital malformations which are outside of normal individual variation and have resulted in significant functional impairment.

d. Inpatient or outpatient expenses, including anesthesia, for which Prior Authorization has been obtained, in

connection with a dental procedure that includes:

(1) Complex oral surgical procedures that have a high probability of complications due to the nature of the surgery;

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

(3) Mental health disorder or intellectual and developmental disability that precludes dental Surgery in the office;

(4) Use of general anesthesia and the Member's medical condition requires that such procedure be performed in a Hospital; or

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

e. Removal of impacted teeth, including wisdom teeth.

Benefits are available for the diagnosis and treatment of temporomandibular joint syndrome or dysfunction (TMJ or TMD) and associated pain of the joint between the temporal bones and the mandible.

Non-surgical TMJ includes: (1) history exam; (2) office visit; (3) x-rays; (4) diagnostic study casts; (5) medications; and (6) appliances to stabilize jaw joint and medications.

2. Exclusions

a. Services as a result of an injury to the jaw, natural teeth, mouth, or face must be started within one year from the date of the injury.

b. The facility charges for surgery will be Covered under the conditions of the inpatient or outpatient facility benefit.

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

d. Treatment for correction of underbite, overbite, and misalignment of the teeth, including braces for dental indications. This exclusion does not apply to Medically Necessary orthognathic Surgery.

e. Professional Charges except as indicated above.

**N. Diagnostic Services**

Medically Necessary and Medically Appropriate diagnostic radiology services and laboratory tests.

1. Covered

a. Non-routine Diagnostic Services (see Attachment C, Schedule of Benefits for a list of Non-routine Diagnostic Services.)

b. All other diagnostic services.

2. Exclusions

a. Diagnostic services that are not Medically Necessary and Medically Appropriate.

**O. Durable Medical Equipment**

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

1. Covered

a. Rental of Durable Medical Equipment - Maximum allowable rental charge not to exceed the total Maximum Allowable Charge for purchase.

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

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

d. Supplies and accessories necessary for the effective functioning of Covered Durable Medical Equipment.

e. The replacement of items needed as the result of normal wear and tear, defects or aging.

2. Exclusions

a. Charges exceeding the total cost of the Maximum Allowable Charge to purchase the Durable Medical Equipment.

b. Duplicate equipment.

c. Supplies and accessories that are not necessary for the effective functioning of the Covered Durable Medical Equipment.

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

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

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

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

h. Portable ramp for a wheelchair.

**P. <u>Prosthetics/Orthotics</u>**

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

Prior Authorization is required for certain prosthetics/orthotics; if Prior Authorization is not obtained, benefits may be reduced. Hearing Aids are not considered to be prosthetics or orthotics; see the "Hearing Aid" section for benefits.

1. Covered

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

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

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

d. The replacement of Covered items that need replacement due to the Member's growth, normal wear and tear, defects or aging.

e. The initial purchase of artificial limbs, eyes, or contacts after cataract surgery.

2. Exclusions

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

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

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

d. Duplicate equipment.

Q. **<u>Hearing Aids</u>**

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

1. Covered Services

The initial purchase of Covered Hearing Aids for Members under age 18, limited as indicated in "Attachment C: Schedule of Benefits." The repair, adjustment or replacement of components and accessories necessary for the effective functioning of Covered equipment, except as otherwise indicated under Exclusions.

2. Exclusions

a. Hearing Aids for Members age 18 or older.

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

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

**R. Supplies**

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

1. Covered

   a. Supplies for the treatment of disease or injury used in a Practitioner's office, outpatient facility, or inpatient facility.

   b. Supplies for treatment of disease or injury that cannot be obtained without a Practitioner's prescription.

2. Exclusions

   a. Supplies that can be obtained without a prescription, except for diabetic supplies. Examples include but are not limited to: (1) Band-Aids; (2) dressing material for home use; (3) antiseptics, (4) medicated creams and ointments; (5) Q-tips; and (6) eyewash.

   b. Supplies must have a Practitioner's prescription if used in the home setting or otherwise for self-use, unless prescribed by a Practitioner and both Medically Necessary and Medically Appropriate.

**S. Home Health Care Services**

Medically Necessary and Medically Appropriate services and supplies authorized by the Plan and provided in a Member's home by an agency who is primarily engaged in providing home health care services.

1. Covered

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

   b. Home Infusion Therapy.

   c. Rehabilitative therapies such as physical therapy, occupational therapy, etc. (subject to the limitations of the Therapeutic/Rehabilitative benefit).

   d. Medical social services.

   e. Dietary guidance.

   f. Services are limited. See Attachment C, Schedule of Benefits.

2. Exclusions

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

   b. BlueCross' Medical Policy may limit the number of visits per hour per day.

   c. Prior Authorization must be obtained from the administrator for services.

**T. Hospice**

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

1. Covered

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

2. Exclusions

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

   b. Prior Authorization must be obtained from the administrator for services.

**U. Behavioral Health Program**

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

Prior Authorization may be required for:

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

b) Partial hospitalization programs.

c) Intensive outpatient treatment programs.

d) Certain outpatient Behavioral Health Services including, but not limited to, transcranial magnetic stimulation (TMS), applied behavior analysis (ABA) therapy and psychological testing.

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

1. Covered

   a. Inpatient services for care and treatment of mental health and substance use disorders.

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

   c. Practitioner visits for care and treatment of mental health and substance use disorders.

   d. Medication Assisted Treatment (MAT), including drugs used for substance use disorder administered or dispensed directly by a Practitioner.

   e. Telehealth.

2. Exclusions

   a. Non-emergency behavioral health Acute care, residential care, partial hospitalization, intensive outpatient programs stays or treatment in halfway houses or group homes, and electro-convulsive treatments that are not Prior Authorized during Your treatment in a facility or program, whether the facility or program is a Network Provider or an Out-of-Network Provider. Emergency Care Services require a notification within 24 hours to receive Prior Authorization.

   b. Marriage and family counseling without a behavioral health diagnosis.

   c. Vocational and educational training and/or services.

   d. Custodial or domiciliary care.

   e. Conditions without recognizable ICD codes, such as adult child of alcoholics, co-dependency and self-help programs.

   f. Sleep disorders.

   g. Behavioral problems such as anti-social personality disorders, sexual deviation or dysfunction or social maladjustment.

   h. Any care in lieu of legal involvement or incarceration.

   i. Pain management.

   j. Biofeedback.

   k. Call the toll-free number indicated on the back of the membership ID card if you have questions about Your Behavioral Health Services benefit.

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

## V. Vision

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

1. Covered

   a. Services and supplies for the diagnosis and treatment of diseases and injuries to the eye.

   b. First set of eyeglasses or contact lens required to adjust for vision changes due to cataract Surgery and obtained within 6 months following the Surgery.

   c. Contact lenses for the treatment of keratoconus.

   d. One (1) retinopathy screening for diabetics per Annual Benefit Period.

2. Exclusions

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

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

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

   c. Eye exercises and/or therapy.

   d. Visual training.

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

## W. 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:

      – dispensed by a licensed pharmacist or dispensing Practitioner on or after Your Coverage begins;

      – approved for use by the Food and Drug Administration (FDA); and

      – listed on the Drug 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. Immunizations administered at a Network Pharmacy.

   f. 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.

   g. Step Therapy is a form of Prior Authorization. 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.

   h. 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.

      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

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

   a. Prescription Drugs not on the 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 stated in this EOC;

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

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

e. any Prescription Drugs that exceed Quantity Limits specified by the Administrator's P & T Committee, or its delegate;

f. any Prescription Drugs purchased outside the United States, except those authorized by Us;

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

h. medications intended to terminate a pregnancy;

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

j. artificial appliances;

k. any Prescription Drugs or medicines dispensed more than one year following the date of the Prescription;

l. Prescription Drugs You receive without charge in accordance 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. Prescription and over-the-counter (OTC) nicotine replacement therapy and aids to smoking cessation including, but not limited to, patches, except as required by the Affordable Care Act;

r. all newly FDA approved drugs prior to review by the Administrator's P & T Committee, or its delegate. Prescription Drugs that represent an advance over available therapy according to the P & T Committee, or its delegate 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;

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

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

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

v. drugs used to enhance athletic performance;

w. Experimental and/or Investigational Drugs; and

x. Compound Drugs, unless Medically Necessary and Medically Appropriate.

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

z. Prescription and non-Prescription medical supplies, devices and appliances, except for syringes used in conjunction with injectable medications or other supplies used in the treatment of diabetes and/or asthma.

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

bb. Prescription medications for puberty blockers or hormones prescribed, administered, or dispensed to Members under age 18 for purposes of gender dysphoria, gender identity disorder,

gender incongruence, or similar conditions, unless such medications are (1) permissive under applicable law; and (2) Medically Necessary and Medically Appropriate. The Administrator reserves the right to request that Providers submit an attestation certifying the medications are in compliance with any and all applicable state and federal laws.

These exclusions only apply to this section. Items that are excluded under this section 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 toll-free number shown on the back of Your Member ID card.

4. DEFINITIONS

a. **Average Wholesale Price** – A published suggested wholesale price of the drug by the manufacturer.

b. **Brand Name Drug** – A Prescription Drug identified by its registered trademark or product name given by its manufacturer, labeler or distributor.

c. **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.

d. **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.

e. **Drug Deductible** - The amount You must pay before benefits are provided for Prescription Drugs. The Drug Deductible will not apply toward satisfying any other Deductible or Out-Of-Pocket Maximum.

f. **Drug Formulary - Preferred** – A list of specific generic and brand name Prescription Drugs Covered by the Administrator, or its delegate, subject to Quantity Limitations, Prior Authorization, and Step Therapy. The Drug Formulary is subject to periodic review and modification at least annually by the Administrator's, or its delegate'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.

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

h. **Generic Drug** - a Prescription Drug that has the same active ingredients, strength or concentration, dosage form and route of administration as a Preferred Brand Drug or Non-Preferred Brand Drug. The FDA approves each Generic Drug as safe and effective as a specific Preferred Brand Drug or Non-Preferred Brand Drug. Generic Drugs may be available as preferred Generic Drugs and non-preferred Generic Drugs and are identified on the Drug Formulary, which can be found at bcbst.com or by calling the Member Service number on the back of Your ID card.

i. **Home Delivery Network** – BlueCross BlueShield of Tennessee's network of pharmaceutical providers that deliver prescriptions through mail service providers to Your home.

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

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

l. **Non Preferred Brand Drug or Elective Drug** - A Brand Name Drug that is not considered a Preferred Drug by the Administrator. Usually there are lower cost alternatives to some Brand Name Drugs.

m. **Out-of-Network Pharmacy** - A Pharmacy that has not entered into a service agreement with the administrator or its agent to provide benefits at specified rates to You.

n. **Pharmacy/Pharmacies** - A state or federally licensed establishment which 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.

o. **Pharmacy and Therapeutics Committee or P&T Committee** - A panel of the Administrator's participating pharmacists, Network Providers, medical directors and pharmacy directors which reviews medications for safety, efficacy and cost effectiveness, on behalf of the Administrator or its delegate. The P&T Committee, or its delegate, evaluates medications for addition and deletion from the: (1) Drug Formulary; (2) Preferred Brand Drug list; (3) Prior Authorization Drug list; and (4) Quantity Limitation list. The P&T Committee may also set dispensing limits on medications.

p. **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 Home Delivery Network.

q. **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.

r. **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.

s. **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.

t. **Prescription Drugs** – A medication that may not be dispensed under applicable state or federal law without a Prescription.

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

v. **Quantity Limitation** – Quantity limitations applied to certain Prescription Drug products as determined by the P&T Committee, or its delegate.

w. **Specialty Drugs** – Injectable, infusion and select oral medications that require complex care, including special handling, patient education and continuous monitoring. Specialty Drugs are categorized as provider-administered or self-administered. Specialty Drugs may be available preferred Specialty Drug or a non-preferred Specialty Drug and are identified on the Drug Formulary, which can be found at bcbst.com or by calling the Member Service number on the back of Your ID card.

x. **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 You.

y. **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.

**X. 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.

2. Exclusions

    a) Prescription drugs, except as indicated in this EOC.

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

    c) Puberty blockers or hormones administered or dispensed to Members under age 18 for purposes of gender dysphoria, gender identity disorder, gender incongruence, or similar conditions, unless such services or medications are (1) permissive under applicable law; and (2) Medically Necessary and Medically Appropriate. The Administrator reserves the right to request that Providers submit an attestation certifying the services or medications are in compliance with any and all applicable state and federal laws.

**Y. <u>Specialty Drugs</u>**

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 when dispensed by a Pharmacy in Our Specialty Pharmacy Network. The current list can be found as 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 when dispensed by a Pharmacy in Our Specialty Pharmacy Network. The Drug Formulary 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 that are not dispensed by a Pharmacy in Our Specialty Pharmacy Network.

    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.

    c. Provider-administered Specialty Drugs that are not dispensed by a Pharmacy in Our Specialty Pharmacy Network.

**EVIDENCE OF COVERAGE**

**ATTACHMENT B:**
**EXCLUSIONS FROM COVERAGE**

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

1. Services or supplies not listed as Covered Services under Attachment A, Covered Services.
2. Services or supplies that are determined to be not Medically Necessary and Medically Appropriate or have not been authorized by the Plan.
3. Services or supplies that are experimental or Investigational in nature including, but not limited to: (1) drugs; (2) biologicals; (3) medications; (4) devices; and (5) treatments.
4. When more than one treatment alternative exists, all are Medically Appropriate and Medically Necessary, and either would meet Your needs, the Plan reserves the right to provide payment for the least expensive Covered Service alternative.
5. Illness or injury resulting from war and covered by: (1) veteran's benefit; or (2) other coverage for which You are legally entitled and which occurred before Your Coverage began under this EOC.
6. Self-treatment or training.
7. Staff consultations required by Hospital or other facility rules.
8. Services that are free.
9. Services or supplies for the treatment of work related illness or injury, regardless of the presence or absence of workers' compensation coverage.
10. Personal, physical fitness, recreational and Convenience Items and services such as: (1) barber and beauty services; (2) television; (3) air conditioners; (4) humidifiers; (5) air filters; (6) heaters, (7) physical fitness equipment; (8) saunas; (9) whirlpools; (10) water purifiers; (11) swimming pools; (12) tanning beds; (13) weight loss programs; (14) physical fitness programs; or (15) self-help devices, programs or applications (including but not limited to mobile medical applications) of any type, whether for medical, behavioral health or non-medical use, unless such mobile application is required by state or federal law or approved in advance by BlueCross to be used in connection with a wellness program offered by BlueCross.
11. Services that are not ordered, provided, or Authorized by Your Physician.
12. Services or supplies received before Your effective date for Coverage with this Plan.
13. Services or supplies related to a Hospital Confinement, received before Your effective date for Coverage with this Plan.
14. Services or supplies received in a dental or medical department maintained by or on behalf of the Employer, mutual benefit association, labor union or similar group.
15. Charges for telephone consultations, e-mail or web based consultations, except as otherwise stated in this EOC.
16. Services for providing requested medical information or completing forms. We will not charge You or Your legal representative for statutorily required copying charges.
17. Court ordered examinations and treatment, unless Medically Necessary.
18. Room, board and general nursing care rendered on the date of discharge, unless admission and discharge occur on the same day.
19. Charges in excess of the Maximum Allowable Charge for Covered Services.
20. Any service stated in Attachment A as a non-Covered Service or limitation.
21. Charges for services performed by You or Your spouse, or Your or Your spouse's parent, sister, brother or child.
22. Any charges for handling fees.
23. Unless Covered in the "Drugs – Prescription Coverage" section in this EOC, nicotine replacement therapy and aids to smoking cessation including, but not limited to, patches.
24. Human growth hormones, unless Covered in the "Drugs – Prescription Coverage" section.
25. Safety items, or items to affect performance primarily in sports-related activities.
26. Services or supplies, including bariatric Surgery, for weight loss or to treat obesity, even if You have other health conditions that might be helped by weight loss or reduction of obesity. This

exclusion applies whether You are of normal weight, overweight, obese or morbidly obese.

27. Services considered Cosmetic, except when Medically Necessary and Medically Appropriate. This exclusion also applies to Surgeries to improve appearance following a prior Surgical Procedure, even if that prior procedure was a Covered Service. Services that could be considered Cosmetic include, but are not limited to: (1) breast augmentation; (2) sclerotherapy injections, laser or other treatment of spider veins and varicose veins; (3) rhinoplasty; (4) panniculectomy/abdominoplasty; and (5) Botulinum toxin.
28. Services that are always considered Cosmetic include, but are 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) brachioplasty; (8) keloid removal; (9) dermabrasion; (10) chemical peels; and (11) laser resurfacing.
29. Lipectomy for cosmetic purpose or for the treatment of variations in fat distribution.
30. Charges relating to surrogate pregnancy when the surrogate mother is not a Covered Member under this Plan.
31. Sperm preservation.
32. Unless Covered in the "Drugs – Prescription Coverage" section, services or supplies to treat sexual dysfunction, including but not limited to erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido. This exclusion does not apply to office visits.
33. Services or supplies related to treatment of complications (except complications of pregnancy) that are a direct or closely related result of a Member's refusal to accept treatment, medicines, or a course of treatment that a Provider has recommended or has been determined to be Medically Necessary, including leaving an inpatient medical facility against the advice of the treating Physician.
34. Services for planned maternity delivery in a home setting or location other than a licensed Hospital or birthing center.
35. Services or supplies related to complications of non-covered services.
36. Services or supplies related to complications of cosmetic procedures, complications of bariatric Surgery; re-operation of bariatric Surgery or body remodeling after weight loss.
37. Compound drugs, unless Medically Necessary and Medically Appropriate.
38. Travel immunizations not received through Your pharmacy benefit.
39. Medical tourism or care received outside the United States when You choose to have an elective procedure in another country.
40. Non-emergency and non-urgent medical services or supplies received while traveling outside of the United States when treatment could have been reasonably delayed.
41. Home delivery of childbirth and any related services, unless the delivery is performed by a provider licensed by the state board of nursing as a registered nurse and duly certified as a nurse midwife by the American College of Nurse-Midwives.
42. Boarding school programs, wilderness treatment programs or similar programs, whether or not the program is part of a residential treatment facility or otherwise licensed institution. This exclusion applies to programs that treat medical conditions, surgical conditions, behavioral health conditions and substance use disorder.
43. Services that do not require a licensed professional and may be provided by non-clinical personnel. This includes art therapy, music therapy, dance therapy, horseback therapy, and other forms of alternative treatment as defined by the National Center for Complementary and Integrative Health (NCCIH).
44. Virtual reality therapy services, devices, and software.

**EVIDENCE OF COVERAGE**

**ATTACHMENT C: PPO SCHEDULE OF BENEFITS**

**Group Name: CO-OP HEALTH & WELFARE PLAN AND TRUST**
**Group Number: 82044**
**Annual Benefit Period: January 1, 2025 to December 31, 2025**

**The Plan 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.**

**Out-of-Network benefit percentages apply to the Maximum Allowable Charge, not to the Provider's Billed Charge, unless otherwise stated. When using Out-of-Network Providers or Non-Contracted Providers, You may be responsible for any unpaid Billed Charges. This amount can be substantial. For more information, please refer to the definitions of Coinsurance and Maximum Allowable Charge in the "Definitions" section of this EOC.**

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

1. Emergency Care Services rendered at an out-of-network hospital Emergency department or a licensed freestanding Emergency department.

2. Covered items and services rendered by an Out-of-Network Provider at an in-network hospital. Note that in certain circumstances, You may agree to receive treatment from an Out-of-Network Provider and waive balance billing protections, provided that You provide consent prior to treatment, and that Your consent satisfies applicable regulatory requirements.

3. Emergent and other Authorized air ambulance services (the same criteria to determine if services from an in-network air ambulance Provider are Covered is used to determine whether services from an out-of-network air ambulance Provider are Covered).

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

| Covered Services | In-Network Benefits for Covered Services received from Network Providers [1] | Out-of-Network Benefits for Covered Services received from Out-of-Network Providers [2] |
|---|---|---|
| **Preventive Health Care Services** | | |
| Well Child Care (to age 6) | 100% | 60% of the Maximum Allowable Charge after Deductible |
| Well Woman Exam | 100% | 60% of the Maximum Allowable Charge after Deductible |
| Mammogram, Cervical cancer Screening and Prostate cancer Screening | 100% | 60% of the Maximum Allowable Charge after Deductible |
| Immunizations | 100% | 60% of the Maximum Allowable Charge after Deductible |

| Covered Services | In-Network Benefits for Covered Services received from Network Providers [1] | Out-of-Network Benefits for Covered Services received from Out-of-Network Providers [2] |
|---|---|---|
| Preventive/Well Care Services<br><br>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/or congestive heart failure limited to 12 visits annually. | 100% | 60% of the Maximum Allowable Charge after Deductible |
| Other Well Care Screenings, age 6 and above including flexible sigmoidoscopy or colonoscopy | 100% | 60% of the Maximum Allowable Charge after Deductible |
| Lactation support services by a trained provider during pregnancy or in the post-partum period. | 100% | 60% of the Maximum Allowable Charge after Deductible |
| Breast Pump, limited to one per pregnancy, and related supplies | 100% | 60% of the Maximum Allowable Charge after Deductible |
| FDA-approved contraceptive methods, sterilization procedures and counseling for women with reproductive capacity. | 100% | 60% of the Maximum Allowable Charge after Deductible |
| One (1) retinopathy screening for diabetics per Annual Benefit Period | 100% | Not Covered |
| Hemoglobin A1C test | 100% | 60% of the Maximum Allowable Charge after Deductible |

| Covered Services | In-Network Benefits for Covered Services received from Network Providers [1] | Out-of-Network Benefits for Covered Services received from Out-of-Network Providers [2] |
|---|---|---|
| **Services Received at the Practitioner's office** | | |
| **Office Exams and Consultations** | | |
| Diagnosis and treatment of injury or illness, including medical and behavioral health conditions. | 80% after Deductible | 60% of the Maximum Allowable Charge after Deductible |
| Maternity office visits | 80% after Deductible | 60% of the Maximum Allowable Charge after Deductible |
| **Injections and Immunizations** | | |
| Allergy injections and allergy serum | 80% after Deductible | 60% of the Maximum Allowable Charge after Deductible |
| All other injections | 80% after Deductible | 60% of the Maximum Allowable Charge after Deductible |
| **Diagnostic Services (e.g. x-ray and labwork)** | | |
| Allergy Testing | 80% after Deductible | 60% of the Maximum Allowable Charge after Deductible |
| Non-Routine Diagnostic Services for illness or injury [3] | 80% after Deductible | 60% of the Maximum Allowable Charge after Deductible |
| All Other Diagnostic Services for illness or injury | 80% after Deductible | 60% of the Maximum Allowable Charge after Deductible |
| Maternity care diagnostic services | 80% after Deductible | 60% of the Maximum Allowable Charge after Deductible |
| Supplemental breast screenings and related diagnostic imaging consisting of mammography, ultrasound imaging, or magnetic resonance imaging | 100% | 60% of the Maximum Allowable Charge after Deductible |
| **Other office procedures, services or supplies** | | |
| Office Surgery, including anesthesia [5, 6] | 80% after Deductible | 60% of the Maximum Allowable Charge after Deductible |
| Therapy Services:<br>Physical, speech and occupational limited to 30 visits per therapy type per Annual Benefit Period;<br>Cardiac and pulmonary rehab limited to 36 visits per therapy type per Annual Benefit Period<br><br>Limits do not apply to services for treatment of autism spectrum disorders. | 80% after Deductible | 60% of the Maximum Allowable Charge after Deductible |
| Chiropractor services, limited to 20 visits per Annual Benefit Period | 80% after Deductible | 60% of the Maximum Allowable Charge after Deductible |
| DME, Orthotics and Prosthetics | 80% after Deductible | 60% of the Maximum Allowable Charge after Deductible |
| Supplies | 80% after Deductible | 60% of the Maximum Allowable Charge after Deductible |
| All Other Office services | 80% after Deductible | 60% of the Maximum Allowable Charge after Deductible |
| **Services Received at a Facility** | | |
| **Inpatient Hospital Stays and Behavioral Health Services [4]** | | |
| Facility charges | 80% after Deductible | 60% of the Maximum Allowable Charge after Deductible |

| Covered Services | In-Network Benefits for Covered Services received from Network Providers [1] | Out-of-Network Benefits for Covered Services received from Out-of-Network Providers [2] |
|---|---|---|
| Practitioner charges | 80% after Deductible | 60% of the Maximum Allowable Charge after Deductible |
| **Skilled Nursing or Rehab Facility stays [4] (Limited to 60 days per Annual Benefit Period combined)** | | |
| Facility charges | 80% after Deductible | 60% of the Maximum Allowable Charge after Deductible |
| Practitioner charges | 80% after 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.) | | |
| Emergency Room charges | 80% after Deductible | 80% of the Maximum Allowable Charge after Deductible |
| Non-Routine Diagnostic Services [3] | 80% after Deductible | 80% of the Maximum Allowable Charge after Deductible |
| All Other Hospital charges | 80% after Deductible | 80% of the Maximum Allowable Charge after Deductible |
| Practitioner Charges | 80% after Deductible | 80% of the Maximum Allowable Charge after Deductible |
| **Outpatient Facility Services including Behavioral Health Intensive Outpatient and Partial Hospitalization [5, 6]** | | |
| Facility charges | 80% after Deductible | 60% of the Maximum Allowable Charge after Deductible |
| Practitioner charges | 80% after Deductible | 60% of the Maximum Allowable Charge after Deductible |
| **Outpatient Diagnostic Services** | | |
| Non-Routine Diagnostic Services for illness or injury [3] | 80% after Deductible | 60% of the Maximum Allowable Charge after Deductible |
| All other Diagnostic Services for illness or injury | 80% after Deductible | 60% of the Maximum Allowable Charge after Deductible |
| Maternity care diagnostic services | 80% after Deductible | 60% of the Maximum Allowable Charge after Deductible |
| Supplemental breast screenings and related diagnostic imaging consisting of mammography, ultrasound imaging, or magnetic resonance imaging | 100% | 60% of the Maximum Allowable Charge after Deductible |
| **Other Outpatient procedures services, or supplies** | | |
| Therapy Services:<br>Physical, speech and occupational limited to 30 visits per therapy type per Annual Benefit Period;<br>Cardiac and pulmonary rehab limited to 36 visits per therapy type per Annual Benefit Period | 80% after Deductible | 60% of the Maximum Allowable Charge after Deductible |
| Chiropractor services, limited to 20 visits per Annual Benefit Period | 80% after Deductible | 60% of the Maximum Allowable Charge after Deductible |
| DME, Orthotics and Prosthetics | 80% after Deductible | 60% of the Maximum Allowable Charge after Deductible |
| Supplies | 80% after Deductible | 60% of the Maximum Allowable Charge after Deductible |
| All Other services received at an Outpatient Facility, including chemotherapy, radiation therapy, injections, infusions, and dialysis | 80% after Deductible | 60% of the Maximum Allowable Charge after Deductible |

| Covered Services | In-Network Benefits for Covered Services received from Network Providers [1] | | Out-of-Network Benefits for Covered Services received from Out-of-Network Providers [2] |
|---|---|---|---|
| **Other Services** | | | |
| Ambulance | 80% after Deductible | | 80% of the Maximum Allowable Charge after Deductible |
| Air Ambulance | 80% after Deductible | | 60% of the Maximum Allowable Charge after Deductible |
| Home health care services [7] | 80% after Deductible | | 60% of the Maximum Allowable Charge after Deductible |
| Home Infusion Therapy [7] | 80% after Deductible | | 60% of the Maximum Allowable Charge after Deductible |
| Hospice Care [7] | 80% after Deductible | | 60% of the Maximum Allowable Charge after Deductible |
| DME, Orthotics and Prosthetics | 80% after Deductible | | 60% of the Maximum Allowable Charge after Deductible |
| Supplies | 80% after Deductible | | 60% of the Maximum Allowable Charge after Deductible |
| Evaluation & Testing of Infertility | 80% after Deductible | | 60% of the Maximum Allowable Charge after Deductible |
| Teladoc Health consultations<br><br>See the "Health and Wellness" section of this EOC for more information. | 80% after Deductible | | Not Covered |
| **Medical Vision Care** | | | |
| Vision exam for the treatment of injuries and diseases of the eye | 80% after Deductible | | 60% of the Maximum Allowable Charge after Deductible |
| Frames, lenses, and contacts Covered following treatment and surgery to repair certain injuries and diseases that impair vision | 80% after Deductible | | 60% of the Maximum Allowable Charge after Deductible |
| **Organ Transplant Services** | | | |
| All Transplant Services, except kidney transplants [8] | **Blue Distinction Centers for Transplants (BDCT) Network:**<br><br>100% after Network Deductible, Network Out-of-Pocket Maximum applies. | **Transplant Network:** [9]<br><br>80% after Network Deductible, Network Out-of-Pocket Maximum applies. | **Out-of-Network Providers**:<br><br>60% after Out-of-Network Deductible, amounts over TMAC do not apply to the Out-of-Pocket and are not covered. |
| Kidney Transplant Services [8] | **Network Providers:**<br><br>80% after Network Deductible; Network Out-of-Pocket Maximum applies. | | **Out-of-Network Providers**:<br><br>60% of Maximum Allowable Charge (MAC), after Out-of-Network Deductible. |

| Prescription Drugs | Prescription Drugs for Retail Network and Home Delivery Network | | | | |
|---|---|---|---|---|---|
| | **Preferred Generic Drug** | **Non-Preferred Generic Drug** | **Preferred Brand Drug** | **Non-Preferred Brand Drug** | **Out-of-Network** |
| **RX04 Retail Network** – Up to a 30 day supply | 80% after Deductible | 80% after Deductible | 80% after Deductible | 80% after Deductible | 60% of the Maximum Allowable Charge after Deductible |
| **RX04 Retail Network** - Greater than a 30 day supply | Not Covered; must utilize either **Home Delivery Network or Plus90 Retail Network** | | | | |
| **Home Delivery Network and Plus90 Retail Network** – Up to a 30 day supply | 80% after Deductible | 80% after Deductible | 80% after Deductible | 80% after Deductible | 60% of the Maximum Allowable Charge after Deductible |
| **Home Delivery Network and Plus90 Retail Network** – For a 31 to 60 day supply | 80% after Deductible | 80% after Deductible | 80% after Deductible | 80% after Deductible | 60% of the Maximum Allowable Charge after Deductible |
| **Home Delivery Network and Plus90 Retail Network** – For a 61 to 90 day supply | 80% after Deductible | 80% after Deductible | 80% after Deductible | 80% after Deductible | 60% of the Maximum Allowable Charge after Deductible |

**Self-Administered Specialty Drugs -** To receive benefits for self-administered Specialty Drugs, You must use a Preferred Pharmacy in Our Specialty Pharmacy Network.

Self-administered Specialty Drugs are limited up to a 30 day supply per Prescription.

| Self-administered Specialty Drugs | Preferred Specialty Drug | Non-Preferred Specialty Drug | Out-of-Network |
|---|---|---|---|
| Preferred Specialty Pharmacy Network | 80% after Deductible | 80% after Deductible | Not Covered |

**Provider-Administered Specialty Drugs -** To receive benefits for Provider-administered Specialty Drugs, You must use a Preferred Pharmacy in Our Specialty Pharmacy Network.

Cost share listed for Provider-administered Specialty Drugs is for the medication only. Providers may bill additional charges for the administering of the drug; refer elsewhere in the schedule for applicable benefit (e.g., chemotherapy, labwork).

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

| Provider-administered Specialty Drugs | Preferred Specialty Pharmacy Network | Out-of-Network |
|---|---|---|
| Provider-administered Specialty Drugs, as indicated in the Provider-administered Specialty Drug list | 80% after Deductible | Not Covered |

**Additional Provisions**

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

Some products may be subject to additional Quantity Limits and Step Therapy as adopted by Us.

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.

| **Miscellaneous Limits**: | **In-Network Providers** | **Out-of-Network Providers** |
|---|---|---|
| Deductible | | |
| Individual | $1,800 | $3,550 |
| Family | $3,600 | $7,100 |
| Out-of-Pocket Maximum | | |
| Individual | $4,000 | $10,200 |
| Family | $8,000 | $20,500 |

1. Benefit percentages apply to BlueCross Maximum Allowable Charge. In-Network level applies to services received from Network Providers and Non-Contracted Providers. Member is responsible for any amount exceeding Maximum Allowable Charge for services received from Non-Contracted Providers.
2. Out-of-Network benefit percentages apply to BlueCross Maximum Allowable Charge. Member may be responsible for any amount exceeding the Maximum Allowable Charge for services received from Out-of-Network Providers.
3. CT scans, MRIs, PET scans, nuclear medicine and other similar technologies.
4. Prior Authorization required. Inpatient hospital stays (except initial maternity admission and Emergency admissions) and Behavioral Health Services require a Prior Authorization. Benefits may be reduced to 50% for Out-of-Network Providers and to 50% for Network Providers outside Tennessee (BlueCard PPO Providers) when Prior Authorization is not obtained. (See the Prior Authorization section for more information.) Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization.
5. Some procedures require Prior Authorization. Call Our consumer advisors to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, benefits will be reduced as described above (#4).
6. Surgeries include invasive diagnostic services (e.g., colonoscopy, sigmoidoscopy).
7. Prior Authorization required.
8. All Transplant Services require Prior Authorization. Call customer service 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.
9. Network Providers not in our Transplant Network include Network Providers in Tennessee and BlueCard PPO Providers outside Tennessee.

## EVIDENCE OF COVERAGE

## PLAN IDENTIFICATION

| | |
|---|---|
| Plan Name: | Co-op Health & Welfare Plan and Trust |
| Name and Address of Plan Administrator: | John Cain, Risk Manager<br>Tennessee Farmers' Cooperative<br>180 Old Nashville Highway, P.O. Box 3003<br>LaVergne, TN 37086 |
| Employer's Tax ID Number: | 62-1216426 |
| Plan Number: | 506 |
| Group Number: | 82044 |
| Agent for Legal Process: | Elizabeth Foss, General Counsel<br>Tennessee Farmers' Cooperative<br>180 Old Nashville Highway, P.O. Box 3003<br>LaVergne, TN 37086 |
| Claim Administrator | BlueCross BlueShield of Tennessee, Inc.<br>1 Cameron Hill Circle<br>Chattanooga, TN 37402 |
| Type of Administration: | Self-funded in accordance with the provisions in this Benefit Plan Document and an excess risk contract. BlueCross BlueShield of Tennessee, Inc., is a contractual, not a fiduciary administrator. |
| Plan Year Ends: | December 31 |
| Type of Plan: | Employee Welfare Plan |
| Plan Cost: | Employees: Contributory<br>Dependents: Contributory |
| Loss of Coverage: | The Employer may change or terminate the Plan at any time without the consent of Covered Persons. |

**The Plan Sponsor reserves the right to terminate, suspend, withdraw, amend or modify the Plan at any time. Any such change or termination in benefits: (a) will be based solely on the decision of the Plan Sponsor; and (b) may apply to active Employees, future retirees and current retirees either as separate groups or as one group.**

## EVIDENCE OF COVERAGE

## ATTACHMENT D: STATEMENT OF ERISA RIGHTS

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

1. Examine, without charge, at the office of the Plan Administrator (Plan Sponsor, usually the Employer) and at other specified locations, such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;
2. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator (Plan Sponsor, i.e., the Employer). The Plan Administrator may make a reasonable charge for these copies; and
3. Receive a summary of the plan's annual financial report. The Plan Administrator (Plan Sponsor, usually the Employer) is required by law to furnish each participant with a copy of this summary annual report.
4. Obtain a statement telling You whether You have a right to receive a pension at normal retirement age and if so, what Your benefits would be at normal retirement age if You stop working under the Plan now. If You do not have a right to a pension, the statement will tell You how many more years You have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The Plan must provide the statement free of charge.
5. Continue Your health care coverage if there is a loss of coverage under the Plan as a result of a qualifying event. You may have to pay for such coverage. Review the Continuation of Coverage section of this EOC for the rules governing your COBRA continuation coverage rights.

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

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

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

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

## 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:

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

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

## UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

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

## QUALIFIED MEDICAL CHILD SUPPORT ORDER PROCEDURE

ERISA and the Child Support Performance and Incentive Act of 1998 (CSPIA) require the Employer to take certain actions to help enforce state administrative and court orders for medical child support.

The Employer adopts the following procedures under ERISA to determine whether medical child support orders qualify with ERISA's requirements and are to be carried out. The Employer may modify or terminate these procedures to satisfy legal requirements.

A qualified medical child support order (QMCSO) establishes a child's right to receive benefits for which a plan participant or qualified beneficiary for continuation of coverage is eligible, and which the Plan has determined meets the requirements to be a qualified medical child support order. To qualify, a medical child support order must:

- Specify the name and last known mailing address of the Employee and the name and mailing address of each child covered by the order; and
- Include a reasonable description of the type of coverage to be provided by the Plan to each child, or the manner in which such type of coverage is to be determined; and
- Specify each period to which such order applies; and
- Specify each plan to which such order applies.

A QMCSO must not require the Plan to provide any type or form of benefit or any option not otherwise provided under the Plan, except to meet requirements of Section 1908 of the Social Security Act (relating to enforcement of state laws regarding child support and reimbursement of Medicaid.) Upon receiving a medical child support order, the Employer shall:

1. Promptly notify in writing the Employee, each child covered by the order, and each representative for these parties of the receipt of the medical child support order. The notice shall include a copy of the order and these QMCSO procedures for determining if the order is qualified;
2. Permit the child to designate a representative to receive copies of notices sent to the alternate recipient regarding the medical child support order;
3. Within a reasonable time after receiving a medical child support order, determine if it is qualified and notify the Employee and child(ren) subject of the order; and
4. Once the order is determined to be qualified, ensure the child is enrolled according to Plan terms and the order and is otherwise treated by the Plan as a covered beneficiary for ERISA reporting and disclosure purposes. As such, the Plan will distribute to the child a copy of the Summary Plan Description (SPD) and any subsequent material modifications adopted by the Plan Sponsor.

In the event the Plan receives a state administrative or court medical child support order under CSPIA requiring the Employer to withhold Employee contributions for group health coverage for a child, the Employer will determine whether the Employee is covered or eligible under the Plan, and whether the child may be eligible under the Plan.

After the Plan Administrator determines the Employee is subject to income withholding to pay for the child's coverage, the Plan Administrator will then notify the Employee, the child and the child's custodial parent (when that is not the Employee) that Coverage is or will become available. The Plan Administrator will furnish the custodial parent a description of the Coverage available, the Effective Date of the Coverage and any forms, documents or other information needed to put such Coverage into effect, as well as information needed to submit claims for benefits.

The Plan Administrator will determine whether Employee contributions are available to pay for the child(ren)'s coverage. If such funds are available, the Employer will withhold such contributions from Employee income and notify the Employee to that effect. The Plan Administrator will also notify and provide the appropriate enrollment information to BlueCross.

# PRIVACY PRACTICES

Important Privacy Practices Notice

Effective Date: July 1, 2021

**Important Privacy Information**

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

**Legal obligations**

The law requires Co-op Health and Welfare Plan & Trust ("we," "us," "our") to give this notice of privacy practices to all our members. This notice lets you know about our legal duties and your rights when it comes to your information and privacy.

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

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

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

**Co-op Health and Welfare Plan & Trust**
**PO Box 3003**
**LaVergne, TN 37086**
**Telephone: (615) 793-8317**
**Fax: (615) 793-8458**
**Email: jcain@ourcoop.com**

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

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

**Organizations This Notice Covers**

This notice applies to Co-op Health and Welfare Plan & Trust. We may share our members' information with BlueCross BlueShield of Tennessee, Inc. and certain subsidiaries and affiliates of BlueCross BlueShield of Tennessee, Inc. as outlined in this notice. If BlueCross BlueShield of Tennessee, Inc. buys or creates new subsidiaries, they may also be required to follow the privacy practices outlined in this notice.

For additional information, including TTY/TDD users, please call _____. Para obtener ayuda en español, llame al _____.

**How We May Use and Share Your Information**

We typically use your information for treatment, payment or health care operations. Sometimes we are allowed, and sometimes we are required, to use or disclose your information in other ways. This is usually to contribute to the public good, such as public health and research.

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

**Ways We May Use and Share Your Information**

The following are examples of how we may use or disclose your information in accordance with federal and state laws.

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

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

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

**To work with plan sponsors:** We may share your information with your employer-sponsored group health plan (if applicable) for plan administration. Please see your plan documents for all ways a plan sponsor may use this information.

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

**Research:** We may use or share your information in connection with lawful research purposes.

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

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

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

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

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

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

- For workers' compensation claims

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

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

For example, we would need your written authorization for:

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

We will let you know if any of these circumstances arise.

**Your Individual Rights**

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

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

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

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

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

**To get notified of a breach:** The law requires us to notify you after the unauthorized acquisition, access, use, or disclosure of your unsecured information that compromises the security or privacy of the information. This notice must include various data points, such as:

- The date of the breach
- The type of data disclosed
- Who accessed, used or disclosed the information without permission
- Who received your information, if known
- What we did or will do to prevent future breaches

**To ask for confidential communications:** You have the right to ask us in writing to send your information to you at a different address or by a different method if you believe that sending information to you in the normal manner will put you in danger. We have to grant your request if it's reasonable. We will also need information from you, including how and where to communicate with you. Your request must not interfere with payment of your premiums.

If there's an immediate threat, you may make your request by calling the Member Service number on the back of your Member ID card or the Privacy Office. Please follow up your call with a written request as soon as possible.

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

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

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

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

1 Cameron Hill Circle
Chattanooga, Tennessee
37402

# www.bcbst.com

# BENEFIT QUESTIONS?

## Call the Customer Service Number on the membership I.D. Card

**SELF-FUNDED EOC (9/01)**