SUMMARY PLAN DESCRIPTION

For the

SELECT AND CHOICE
MEDICAL PLANS

Sponsored by

CITY OF MEMPHIS

Group Number: 130447

Effective: January 1, 2020

PPO

City of Memphis
Group Number 130447
January 1, 2020

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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.

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1. 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.
2. 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 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 ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711). They can provide you with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address your Nondiscrimination Grievance to: Nondiscrimination Compliance Coordinator; c/o Manager, Operations, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; (423) 591-9208 (fax); Nondiscrimination_OfficeGM@bcbst.com (email).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NOTICE

PLEASE READ THIS SUMMARY PLAN DESCRIPTION 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 SUMMARY PLAN DESCRIPTION OR ANY OTHER MATTER RELATED TO YOUR MEMBERSHIP IN THE PLAN, PLEASE WRITE OR CALL US AT:

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

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INTRODUCTION

This Summary Plan Description (this "SPD") was created for the Employer (listed on the cover of this SPD) as part of its Employee welfare benefit plan (the "Plan"). References in this SPD to "Administrator," "We," "Us," "Our," or "BlueCross" mean BlueCross BlueShield of Tennessee, Inc. The Employer has entered into an Administrative Services Agreement (ASA) with BlueCross for it to administer the claims Payments under the terms of the SPD, and to provide other services. BlueCross does not assume any financial risk or obligation with respect to Plan claims. BlueCross is not the Plan Sponsor, the Plan Administrator or the Plan Fiduciary, as those terms are defined in ERISA. The Employer is the Plan Fiduciary, the Plan Sponsor and the Plan Administrator. These Employee Retirement Income Security Act of 1974 ("ERISA") terms are used in this SPD to clarify their meaning, even though the Plan is not subject to ERISA. Other federal laws may also affect Your Coverage. To the extent applicable, the Plan complies with federal requirements.

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

PLEASE READ THIS SPD CAREFULLY. IT DESCRIBES THE RIGHTS AND DUTIES OF MEMBERS. IT IS IMPORTANT TO READ THE ENTIRE SPD. 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.)

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

ANY GRIEVANCE RELATED TO YOUR COVERAGE UNDER THIS SPD SHALL BE RESOLVED IN ACCORDANCE WITH THE "GRIEVANCE PROCEDURE" SECTION OF THIS SPD.

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

Please contact one of the Administrator's consumer advisors, at the number on the back of Your ID card, if You have any questions when reading this SPD. Our consumer advisors are also available to discuss any other matters related to Your Coverage from the Plan.

BENEFIT ADMINISTRATION ERROR

If the Administrator makes an error in administering the benefits under this SPD, 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 SPD.

NOTIFICATION OF CHANGE IN STATUS

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

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

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

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

ELIGIBILITY

Any Employee of the Employer and his or her family dependents who meet the eligibility requirements of this Section will be eligible for Coverage if properly enrolled for Coverage, 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 SPD.

A. Subscriber

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

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

B. Covered Dependents

To be eligible to enroll as a Covered Dependent, a Member must 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 defined by the Employer, which may include a Domestic Partner; or
2. The Subscriber's or the Subscriber's spouse's: (1) natural child; (2) legally adopted child (including children placed for the purpose of adoption); (3) step-child(ren); or (4) children for whom the Subscriber or Subscriber's spouse is the legal guardian; who are less than 26 years old; or
3. A child of the Subscriber or the Subscriber's spouse for whom a Qualified Medical Child Support Order has been issued; or
4. An Incapacitated Child of the Subscriber or 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.

C. Waiting Period

The Plan has a Waiting Period. Each Employee must wait 30 days after he or she is hired before he or she is eligible for Coverage.

D. Domestic Partner

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

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

Children of Domestic Partners who are not also the legal dependent of the Subscriber are not eligible for Coverage under this SPD.

E. Coverage For Retirees

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

1. Retires from full time employment with Employer; and
2. Is between ages 62 and 64 at the time he or she retirees.

Retirees may be required to pay a portion of the Payment to the Employer. Dependents of Retirees may continue Coverage after the Retiree ceases to be eligible. Check with the Employer for full details**.**

F. Coverage for Non-Employee (NEMPS)

Other individuals approved by the City of Memphis may be allowed coverage provided they meet all requirements that City employees and/or retired employees must meet for coverage.

The City reserves the right to amend this section from time to time at its discretion and agrees to give 60-day written notice of termination of coverage to the group. Termination of coverage by either party will be deemed termination of coverage for all members, retired or active, in the group.

ENROLLMENT IN THE PLAN

Eligible Employees may enroll for Coverage for themselves and their eligible dependents as set forth in this section. No person is eligible to re-enroll if the Plan previously terminated his or her Coverage for any of the reasons listed under paragraph C. of the "When Coverage Ends" section of this SPD.

A. Initial Enrollment Period

Eligible Employees may enroll for Coverage for themselves and their eligible dependents within the first 30 days after becoming eligible for Coverage. The Subscriber must: (1) include all requested information; (2) sign; and (3) submit an Enrollment Form to the Administrator during that initial enrollment period, except as otherwise indicated in paragraph C. below.

B. Open Enrollment Period

Eligible Employees shall be entitled to apply for Coverage for themselves and eligible dependents during their Employer's Open Enrollment Period. The eligible Employee must: (1) include all requested information; (2) sign; and (3) submit an Enrollment Form to the Administrator 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 30 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 30 days of the date that the Subscriber acquires the child.

   If the Subscriber fails to do so, and an additional Premium is required to cover a newborn or newly acquired child, the Plan will not provide Coverage for that child after 30 days from the date the Subscriber or the Subscriber's spouse acquired the child if the Premium was not furnished to the Plan within that time period. If no additional Premium is required to provide Coverage to the child, the Subscriber's failure to enroll the child does not make the child ineligible for Coverage.

   However, the Plan cannot add the 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 the Administrator within 30 days of the date that person first becomes eligible for Coverage.

3. An Employee or eligible dependent who did not apply for Coverage within 30 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;

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

c. Such other coverage is exhausted:

(1) 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

d. Employer contributions for the other coverage ended; andHe or she applies for Coverage under this Plan and the Administrator receives the change form within 30 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 enroll:

1. During a subsequent Open Enrollment Period; or

2. If the Employee acquires a new dependent, and he or she applies for Coverage within 30 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. You 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 Yourself 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 30 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 30 days of the change in status for the following events: (1) Loss of eligibility for Medicaid or Children's Health Insurance Program (CHIP) Coverage, or (2) Becoming eligible to receive a subsidy for Medicaid or CHIP Coverage.

WHEN COVERAGE BEGINS

If You are eligible, have enrolled and have paid or had the Payment for Coverage paid on Your behalf, Coverage under this SPD 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 Employer; or

C. Enrollment During an Initial Enrollment Period

Coverage shall be effective on the first day of the month following the completion of a 30-day Waiting Period if the Plan Administrator receives the properly completed enrollment form and any required contribution for coverage within 31 days of the date the new Eligible Person becomes eligible.; or

D. Newly Eligible Employees

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

E. Newly Eligible Dependents

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

For Coverage to be effective, the dependent must be enrolled, and the Administrator must receive any required completed enrollment application and any required contributions for the Coverage, as set out in the "Enrollment" section; or

F. Actively At Work Rule

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

WHEN COVERAGE ENDS

A. Termination or Modification of Coverage by BlueCross or the Employer

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

All Members' Coverage through the ASA will change or terminate at 12:00 midnight on the date of such modification or termination. The Employer's failure to notify You of the modification or termination of Your Coverage does not continue or extend Your Coverage beyond the date that the ASA is modified or terminated. You have no vested right to Coverage under this SPD 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 of the Employer. Coverage for a Member who has lost his or her eligibility shall automatically terminate at 12:00 midnight on the day that loss of eligibility occurred.

C. Termination or Rescission of Coverage

The Plan may terminate Your Coverage if:

1. You fail to make a required Member Payment when it is due. (The fact that You have made a Payment contribution to the Employer will not prevent the Administrator from terminating Your Coverage if the Employer fails to submit the full Payment for Your Coverage to the Administrator when due); or
2. You fail to cooperate with the Plan or Employer as required; or
3. You have made a 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 ID card.

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 SPD. 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 SPD.

E. Payment For Services Rendered After Termination of Coverage

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

F. Extended Benefits

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

CONTINUATION OF COVERAGE

Federal Law

If Your Coverage under this SPD terminates, You may be offered the right to continue Coverage. This right is referred to as "COBRA Continuation Coverage" and may occur for a limited time subject to the terms of this section and the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

A. Eligibility

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

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

B. Enrolling for COBRA Continuation Coverage

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

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

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

C. Payment

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

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

D. Coverage Provided

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

E. Duration of Eligibility for COBRA Continuation Coverage

COBRA Continuation Coverage is available for a maximum of:

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

F. Termination of COBRA Continuation Coverage

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

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

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

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

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

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

H. Continued Coverage During a Military Leave of Absence

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

I. The Trade Adjustment Assistance Reform Act of 2002

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

PRIOR AUTHORIZATION, CARE MANAGEMENT, MEDICAL POLICY AND PATIENT SAFETY

BlueCross 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 this SPD 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)*
- *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*
- *Certain musculoskeletal procedures (including, but not limited to, spinal Surgeries, spinal injections, and hip, knee and shoulder Surgeries)*
- *Certain Durable Medical Equipment (DME)*
- *Certain Prosthetics*
- *Certain Orthotics*
- *Certain genetic testing*

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

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

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

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

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

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

B. Care Management

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

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

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

In that event, We may elect to offer alternative benefits for services not otherwise specified as Covered Services in “Attachment A: Covered Services and Exclusions”. Such benefits shall not exceed the total amount of benefits under this SPD 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 – We are 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 SPD.

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

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

Medical policies state whether or not a technology is Medically Necessary, Investigational or Cosmetic. As technologies change and improve, and as Members' needs change, We may reevaluate and change medical policies without formal notice. 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 SPD, the medical policy definition controls.

D. Patient Safety

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

HEALTH AND WELLNESS SERVICES

BlueCross provides You with resources to help improve Your health and quality of life through Our interactive Health and Wellness Portal. To learn more about these resources, login to BlueAccess at bcbst.com or call the number on the back of Your ID card.

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

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

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

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

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

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

BlueHealth Rewards℠ – You may be eligible to earn rewards or incentives under the Employer sponsored wellness program. For more information, login to BlueAccess at bcbst.com or contact Us at 1-844-269-2583.

If You think You might not be able to meet a standard for a reward or incentive under the program, You might qualify for an opportunity to earn the same reward by different means. Contact Us at 1-844-269-2583 and We will work with You (and if You wish, with Your doctor) to find a wellness strategy with the same reward that is right for You in light of Your health status.

Lifestyle Health Coaching – This program provides You with health coaching focused on wellness interventions including, but not limited to, blood pressure, cholesterol management, nutrition, physical activity, stress management, tobacco cessation and weight management. It also provides maintenance programs for weight management and tobacco cessation. Health coaches provide You with educational materials pertaining to the health coaching topic(s) in which You are engaged. To speak with a lifestyle health coach, call 1-800-818-8581.

Chronic Condition Management – This program provides Members with coronary artery disease, chronic obstructive pulmonary disease, congestive heart failure, diabetes, asthma and depression access to extra resources and personalized attention. To speak with a nurse about one of these conditions, call 1-800-818-8581 or for hearing impaired dial TTY 1-888-308-7231.

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

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

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

Follow these steps to register and request a consultation:

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

Register a username and password for the service and complete Your medical history prior to Your first consultation.

Request a consultation from a licensed Practitioner.

PhysicianNow consultations do not replace Emergency care or Your primary physician. Restrictions apply in some states where this service is not allowed. Prescriptions are issued only when clinically appropriate. Some Prescriptions, including controlled substances, are excluded from this service. Refer to “Attachment C: Schedule of Benefits” for benefit and cost share information.

Diabetes Prevention Program - The Diabetes Prevention Program (DPP) aims to prevent Members from developing diabetes. Members at risk for developing type 2 diabetes are identified through medical data, claims data and self-administered pre-diabetes screenings. Once enrolled, Members have access to the DPP’s standard suite of tools, including wireless scales, an activity tracker, interactive coaching sessions, online classes, and more, that help the Member make lifestyle changes and decrease their likelihood of developing diabetes. BlueCross’ DPP utilizes a digitally based platform to administer the program.

Diabetes Management Program - Diabetes Management Program. The program aims to reduce hemoglobin A1C levels, emergency room visits and outpatient visits for members with diabetes who participate in the program. The DMP gives the Member access to monitoring via connected meter and real-time insights, unlimited supply of test strips and lancets shipped direct to Member with automated reordering based on usage, 24/7 support and access to clinical coaches for diabetes education and support. Real-time insights help Members share reports with their provider and receive health notifications and reminders to help keep them on track. The DMP utilizes a digitally-based platform to administer the program. Program fees will be charged on a Per Participant Per Month basis as described in Exhibit B.

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.

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

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

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

B. Claims Billing

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

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

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

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

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

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

C. Payment

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

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 repayment from that Provider. You will be responsible for any unpaid billed Charges. The Plan's Payment fully discharges its obligation related to that claim.

3. We will pay benefits according to the Plan within 30 days after We receive a claim form that is complete. Claims are processed in accordance with Our internal administration procedures 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.

4. You will receive a Claim Summary that describes how a claim was treated. The Claim Summary, sometimes referred to as the Explanation of Benefits (EOB), shows how a claim paid, denied, how much was paid to the Provider and will also let You know if You owe an additional amount 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 Our consumer advisors at the number on the back of Your ID card.

5. 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 consumer advisors at the number on the back of Your ID card.

Mail all claim forms to:

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

COORDINATION OF BENEFITS

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

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

A. Definitions

The following terms apply to this provision:

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

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

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

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

4. Primary Plan/Secondary Plan

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

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

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

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

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

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

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

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

B. Order of Benefit Determination Rules

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

1. Non-Dependent/Dependent

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

   a. if the person is also a Medicare beneficiary and,

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

      (1) benefits of the Plan of an active Employee covering the person as a Dependent;

      (2) Medicare;

      (3) benefits of the Plan covering the person as an Employee, Member, or Subscriber.

2. Dependent Child/Parents Not Separated or Divorced

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

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

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

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

3. Dependent Child/Separated or Divorced Parents

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

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

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

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

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

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

4. Active/Inactive Employee

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

5. Longer/Shorter Length of Coverage

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

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

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

(1) A change in the amount or scope of a Plan's benefits;

(2) A change in the entity that pays, provides, or administers the Plan's benefits; or

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

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

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

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

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

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

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

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

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

d. If:

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

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

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

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

C. Effect on the Benefits of this Plan

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

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

D. Right to Receive and Release Needed Information

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

E. Facility of Payment

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

F. Right of Recovery

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

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

3. Other organizations.

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

G. Are You Also Covered by Medicare?

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

GRIEVANCE PROCEDURE

A. INTRODUCTION

Our Grievance Procedure (the "Procedure") is intended to provide a fair, quick and inexpensive method of resolving any and all Disputes with the Plan. Such Disputes include: any matters that cause You to be dissatisfied with any aspect of Your relationship with the Plan; any Adverse Benefit Determination concerning a claim; or any other claim, controversy, or potential cause of action You may have against the Plan. Please contact 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 SPD or other documents related to Your Coverage (e.g., a Claim Summary, sometimes referred to as the 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 SPD. Any decision to award damages must be based upon the terms of this SPD.
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 SPD.

B. DESCRIPTION OF THE REVIEW PROCEDURES

1. Inquiry

   An inquiry is an informal process that may answer questions or resolve a potential Dispute. You should contact 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.

2. First Level Grievance

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

a. Grievance Process

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

b. Written Decision

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

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

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

(3) For a pre-service, Urgent Care claim, within 72 hours of receipt of Your request for review.

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

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

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

(3) Reference to the documentation or information upon which the committee based its decision. You may receive a copy of such documentation or information, without charge, upon written request.

2. Second Level Grievance

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

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

The Plan may require You to exhaust each step of this 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.

a. Grievance Process

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

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

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

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

b. Written Decision

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

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

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

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

3. Independent Review of Medical Necessity Determinations

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

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

bring a civil action against the Employer or Employer's Plan, until the independent reviewer makes its decision.

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

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

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

The reviewer's decision must state the reasons for the determination based upon: (1) the terms of this SPD 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 SPD 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 SPD, they have the meaning set forth in this section.

1. **Actively At Work** – An eligible Employee who is performing all of the Employee's regular duties for the Employer on a regularly scheduled workday at the location where such duties are normally performed. Eligible Employees will be considered to be Actively At Work on a non-scheduled work day (which would include a scheduled vacation day) only if the Employee was Actively At Work on the last regularly scheduled work day.
2. **Acute** – An illness or injury that is both severe and of short duration.
3. **Administrative Services Agreement or ASA** – The arrangements between the Administrator and the Employer, including any amendments, and any attachments to the ASA or this SPD.
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, reduction, termination or failure to provide or make Payment, in whole or in part, for a benefit based on a determination by a health carrier of a Member's eligibility to participate in the health carrier's health benefit plan; or
    c. Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make Payment for, in whole or in part, a benefit.
6. **Annual Benefit Period** - The 12-month period under which Your benefits are administered, as noted in "Attachment C: Schedule of Benefits".
7. **Authorize(d)** – An approval given by the Administrator when, through the Prior Authorization process, it has determined a certain service to be a Covered Service.
8. **Behavioral Health Services** - Any services or supplies to treat a mental or emotional condition or subscriber use disorder.
9. **Billed Charges** – The amount that a Provider charges for services rendered. Billed Charges may be different from the amount that We determine to be the Maximum Allowable Charge for services.
10. **Blue Distinction Centers for Transplants (BDCT) Network** – A network of facilities and hospitals contracted with BlueCross (or with an entity on behalf of BlueCross) to provide Transplant Services for some or all organ and bone marrow transplant

procedures Covered under this SPD, excluding kidney transplants. Facilities obtain designation as a BDCT by transplant type; therefore, a hospital or facility may be classified as a BDCT for one type of organ or bone marrow transplant procedure but not for another type of transplant. This designation is important as it impacts the level of benefit You will receive.

11. **BlueCard PPO Participating Provider** – A physician, hospital, licensed skilled nursing facility, home health care Provider or other Provider contracted with other BlueCross and/or BlueShield Association (BlueCard PPO) Plans and/or Authorized by the Plan to provide Covered Services to Members.

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

13. **Care Management** – Programs that promote cost effective coordination of care for Members with low-risk health conditions and/or certain complicated medical needs.

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

15. **Clinical Trials** - Studies performed with human subjects to test new drugs or combinations of drugs, new approaches to Surgery or radiotherapy or procedures to improve the diagnosis of disease and the quality of life of the patient. Such studies are not Authorized by the Administrator.

16. **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".

    You are responsible for any unpaid Billed Charges 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.

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

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

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

19. **Copay or 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 services.

20. **Cosmetic or Cosmetic Service** – Any surgical or non-surgical treatment, drugs or devices intended to alter or reshape the body for the purpose of improving appearance

or self-esteem. Our Medical Policy establishes the criteria for what is Cosmetic, and what is Medically Necessary and Medically Appropriate.

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

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

23. **Covered Services, Coverage or Covered** – Those Medically Necessary and Medically Appropriate services and supplies that are set forth in "Attachment A: Covered Services and Exclusions" of this SPD, (that is incorporated by reference). Covered Services are subject to all the terms, conditions, exclusions and limitations of the Plan and this SPD.

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

25. **Deductible** – The dollar amount, specified in "Attachment C: Schedule of Benefits", that You must incur and pay for Covered Services during an Annual Benefit Period before the Plan provides benefits for services.

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

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

27. **Drug Copayment** – The dollar amount specified herein that You must pay when the Covered Prescription Drug is dispensed.

28. **Drug Formulary** Preferred – A list of Prescription Drugs Covered by the Administrator and that are subject to Quantity Limits, Prior Authorization, or Step Therapy. The Drug Formulary is subject to periodic review and modification at least annually by the Administrator's P & T Committee. The Drug Formulary can be found at bcbst.com, or by calling the number on the back of Your ID card.

29. **Effective Date** – The date Your Coverage under this SPD begins.

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

    a. serious impairment of bodily functions; or

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

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

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

31. **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.

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

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

34. **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.

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

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

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

38. **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.

39. **Home Delivery Network** – BlueCross' network of mail service Pharmacy facilities that are permitted to mail Prescription Drugs.

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

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

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

    a. If the child reaches this Plan's Limiting Age while Covered under this Plan, proof of such incapacity and dependency must be furnished within 31 days of when the child reaches the Limiting Age.

    b. Incapacitated dependents of Subscribers of new groups, or of Subscribers who are newly eligible under this Plan, are eligible for Coverage if they were covered under the Subscriber's or the Subscriber's spouse's previous health benefit plan.

We may ask You to furnish proof of the incapacity and dependency upon enrollment and for proof that the child continues to meet the conditions of incapacity and dependency, but not more frequently than annually.

43. **Investigational** – The definition of “Investigational” is based on the BlueCross’ technology evaluation criteria. Any technology that fails to meet **ALL** of the following four criteria is considered to be Investigational.

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

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

        (2) Any approval that is granted as an interim step in the FDA or any other federal governmental body’s regulatory process is not sufficient.

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

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

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

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

        (1) The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.

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

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

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

    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 the Department of Health and Human Services (HHS), or

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

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

44. **Late Enrollee** – An Employee or eligible Dependent who fails to apply for Coverage within: (1) 60 days after such person first became eligible for Coverage under this SPD; or (2) a subsequent Open Enrollment Period.

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

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

47. **Maximum Allowable Charge** – The amount that the Administrator, at its discretion, has determined to be the maximum amount payable for a Covered Service, or Prescription Drug. For Covered Services provided by Network Providers, that determination will be based upon the Administrator's contract with the Network Provider for Covered Services rendered by that Provider. For Covered Services provided by Out-of-Network Providers, the amount payable will be based upon the Administrator's Out-of-Network fee schedule for the Covered Services rendered by Out-of-Network Providers. For Out-of-Network Emergency Care Services, the Maximum Allowable Charge for a Covered Service complies with the Affordable Care Act requirement to be based on 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.

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

49. **Medical Director** – The physician designated by the Administrator, or that physician's designee, who is responsible for the Administration of the Administrator's medical management programs, including its Prior Authorization program.

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

a. be Medically Necessary;

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

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

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

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

51. **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: (1) in accordance with generally accepted standards of medical practice; and (2) clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and (3) not primarily for the convenience of the patient, physician or other health care Provider; and (4) 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.

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

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

54. **Member Payment** – The dollar amounts for Covered Services that You are responsible for as set forth in "Attachment C: Schedule of Benefits", including Copayments, Deductibles, Coinsurance and Penalties. The Administrator may require proof that You have made any required Member Payment.

55. **Medication Assisted Treatment (MAT)** – Treatment for persons diagnosed with indicated alcohol or substance use disorder with the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to treatment.

56. **Network Benefit** – The Plan's Payment level that applies to Covered Services received from a Network Provider. See "Attachment C: Schedule of Benefits".

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

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

59. **Non-Contracted Provider** – A Provider that renders Covered Services to a Member, in the situation where We have not contracted with that Provider type to provide those Covered Services. A Non-Contracted Provider is different from an Out-of-Network Provider. A Non-Contracted Provider is not eligible to hold a contract with the Administrator. 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.

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

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

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

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

64. **Out-of-Network Provider** – Any Provider who does not have a contract with the Administrator to provide Covered Services and who is not a Non-Contracted Provider.

65. **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.

66. **Payment** – The total Payment for Coverage under the Plan, including amounts paid by You and the Employer for such Coverage.

67. **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.

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

69. **Pharmacy and Therapeutics Committee or P & T Committee** – A panel of pharmacists and Practitioners that reviews medications for safety, efficacy and cost effectiveness. The P & T Committee evaluates medications for addition and deletion and tier assignment in the Drug Formulary, as well as for Prior Authorization and Quantity Limits requirements.

70. **Plus90 Retail Network** – BlueCross' network of retail Pharmacies that are permitted to dispense Prescription Drugs to You, up to a 90 day supply.

71. **Penalty/Penalties** – An increase in the amount You pay as a result of failure to comply with established requirements. Penalties do not apply to the Out-of-Pocket Maximum.

72. **Practitioner** – A person licensed by the State to provide medical services. The services provided by a Practitioner must be within his or her specialty or scope of practice.

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

74. **Prescription(s)** – A written or verbal order issued by a Practitioner for a drug or medical equipment.

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

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

77. **Preventive Health Exam** – 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: (1) a complete history or interval update of the patient's history and a review of systems; and (2) a physical examination of all major organ systems, and screening tests per the Administrator's Medical Policy.

78. **Prior Authorization** – A review conducted by the Administrator, prior to the delivery of certain services or the reimbursement of certain Prescription Drugs, to determine if such services will be considered Covered Services.

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

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

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

82. **Rescind or Rescission(s)** – 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.

83. **RX04 Retail Network** – BlueCross' network of retail Pharmacies that are permitted to dispense Prescription Drugs to You, up to a 30 day supply.

84. **Specialty Drugs** – Injectable, infusion and select oral medications that require complex care, including special handling, patient education and continuous monitoring.

Specialty Drugs are identified as Provider-administered or self-administered on the Drug Formulary found at bcbst.com. Specialty Drugs may be available as a Generic Drug, Preferred Brand Drug or Non-Preferred Brand Drug.

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

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

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

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

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

90. **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.

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

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

93. **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.

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

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

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

97. **Well Child Care** – A routine visit to a pediatrician or other qualified Practitioner to include Medically Necessary and Medically Appropriate Preventive Health Exams, immunizations and injections for children through age 5.

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

ATTACHMENT A:
COVERED SERVICES AND EXCLUSIONS

EVIDENCE OF COVERAGE

Plan benefits are based on the Maximum Allowable Charge for Medically Necessary and Medically Appropriate services and supplies described in this attachment and provided in accordance with the benefit schedules set forth in "Attachment C: Schedule of Benefits". 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 Utilization Policies. (See the "Prior Authorization, Care Management, Medical Policy and Patient Safety" section for more information.)

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

Please also read "Attachment B: Other Exclusions".

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

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

Obtaining services not listed as a Covered Service in this Attachment or not in accordance with Utilization Policies may result in the denial of benefits or a reduction in reimbursement for otherwise eligible Covered Services.

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

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

A Clinical Trial is a prospective biomedical or behavioral research study of human subjects that is designed to answer specific questions about biomedical or behavioral interventions (vaccines, drugs, treatments, devices, or new ways of using known drugs, treatments, or devices). Clinical Trials are used to determine whether new biomedical or behavioral interventions are safe, efficacious, and effective. **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 Utilization Policies.**

A. Practitioner Office Services

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

1. Covered Services

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

   b. Injections and medications administered in a Practitioner's office, except Specialty Drugs. (See the Specialty Drugs section for information on Coverage).

   c. Second surgical opinions given by a Practitioner who is not in the same medical group as the Practitioner who initially recommended the Surgery.

   d. Telehealth.

   e. Preventive/Well care services.

      Preventive Health Exam and related services for adults and children in accordance with federal regulations, as outlined below and performed by the physician during the Preventive Health Exam or referred by the physician as appropriate, including:

      (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; and (7) weak feet or chronic foot strain.

   b. Rehabilitative therapies in excess of the benefits stated in the Therapeutic/ Rehabilitative Services section.

   c. Dental procedures, except as otherwise indicated in this SPD.

B. Inpatient Hospital Services

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

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

1. Covered Services

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

   b. Attending Practitioner's services for professional care.

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

2. Exclusions

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

   b. Private duty nursing.

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

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

C. Emergency Care Services

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

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

If You go to a Network Provider, You will receive the highest level of benefits for Covered Services and should 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.

If You go to an Out-of-Network Provider, there is no maximum to Your financial liability. The Out-of-Network Provider has the right to bill You for any unpaid Billed Charges; this amount may be substantial.

1. Covered Services

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

   b. Practitioner services.

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

2. Exclusions

a. Services rendered for inpatient care or transfer to another facility once Your medical condition has stabilized, unless Prior Authorization is obtained from the Administrator within 24 hours or the next working day.

D. Ambulance Services

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

1. Covered Services

a. Ambulance Services - Air

(1) Prior Authorization may be required for non-Emergency transportation by air ambulance.

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

b. Ambulance Services - Ground

(1) Prior Authorization may be required for non-Emergency transportation by ground ambulance.

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

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

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

2. Exclusions

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

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

E. Urgent Care Center Services

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

1. Covered Services

a. Diagnosis and treatment of illness or injury.

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

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

d. Surgery and supplies.

2. Exclusions

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

F. Outpatient Facility Services

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

1. Covered Services

a. Practitioner services.

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

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

d. Outpatient Surgery and supplies.

e. Observation stays less than 24 hours.

f. Telehealth.

2. Exclusions

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

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

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 Services

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

b. Sterilization procedures.

c. Services or supplies for the evaluation of infertility.

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

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

2. Exclusions

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

b. Services or supplies for the reversals of sterilizations.

c. Induced abortion unless: (1) the health care Practitioner certifies in writing that the pregnancy would endanger the life of the mother; or (2) the fetus is not viable; or (3) the pregnancy is a result of rape or incest; or (4) the fetus has been diagnosed with a lethal or otherwise significant abnormality.

H. Reconstructive Surgery

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

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

1. Covered Services

   a. Surgery to correct significant defects from congenital causes (except where specifically excluded), accidents or disfigurement from a disease state.

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

   c. Transgender Treatment and Surgery including treatment for gender identity disorders, hormone therapy and medically prescribed sex reassignment.

2. Exclusions

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

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

   c. Voice modification Surgery or voice therapy.

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

I. Skilled Nursing/Rehabilitative Facility Services

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

1. Covered Services

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

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

   c. Coverage is limited as indicated in "Attachment C: Schedule of Benefits".

2. Exclusions

   a. Custodial, domiciliary or private duty nursing services.

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

c. 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 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 Services

   a. Outpatient, home health or office therapeutic and rehabilitative services that are expected to result in significant and measurable improvement in Your condition resulting from an Acute illness, Acute injury, autism, 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; (5) cardiac and pulmonary rehabilitative services, and (6) acupuncture.

      i. Speech therapy is Covered only for disorders of articulation and swallowing, resulting from Acute illness, Acute injury, stroke, autism, or congenital anomaly.

   c. Coverage is limited as indicated in "Attachment C: Schedule of Benefits".

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

      ii. Services received during an inpatient hospital, skilled nursing or rehabilitative facility stay are Covered as shown in the inpatient hospital, skilled nursing or rehabilitative facility section, and are not subject to the therapy visit limits.

2. Exclusions

   a. Treatment beyond what can reasonably be expected to significantly improve health, including therapeutic treatments for ongoing maintenance or palliative care.

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

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

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

e. Behavioral therapy, play therapy, communication therapy, and therapy for self correcting language dysfunctions as part of speech therapy, physical therapy or occupational therapy programs. Behavioral therapy and play therapy for behavioral health diagnoses may be Covered under the Behavioral Health section (if applicable to Your Group Coverage).

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

K. Organ Transplants - All Organ Transplants, Excluding Kidney

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

1. Prior Authorization

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

2. Benefits

Transplant benefits are different than benefits for other services.

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

You have access to two levels of benefits:

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

b. **Transplant Network**: If You want to receive the maximum benefit, You should use a facility in the BDCT Network. If You instead have a transplant performed at a facility in the Transplant Network (non-BDCT), the Administrator will pay at the benefit level listed in "Attachment C: Schedule of Benefits" for the Transplant Network. **Not all Network Providers are in the Transplant Network. Please check with the Transplant Case Management department to determine if the Transplant Network is the best network available for Your specific transplant type.**

c. 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 deemed Medically Necessary and Medically Appropriate and Prior Authorization is obtained

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

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

4. Organ and Tissue Procurement

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

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

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

5. Travel Expenses

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

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

- travel to and from the facility in the BDCT Network for a Covered transplant procedure and required post-transplant follow-up. Any travel expenses for follow-up visits occurring more than 12 months from the date of the transplant are not Covered. Covered travel expenses will not apply to the Deductible or Out-of-Pocket Maximum.
- 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. Non-Covered Services;

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 organ not determined to be Medically Necessary;

e. 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;

f. 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;

g. 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;

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

i. Complications, side effects or injuries 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. Covered travel expenses will not apply to the Deductible or Out-of-Pocket Maximum.
   b. Meals and lodging expenses are Covered up to $150 per day, subject to the following:
      i. Lodging expenses are limited to $50 per person per day.
      ii. Meals are only Covered when provided at the facility where 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. Covered travel expenses will not apply to the Deductible or Out-of-Pocket Maximum if donor is a Member.

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

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

5. Exclusions

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

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

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

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

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

e. Payment to an organ donor or the donor’s family as compensation for a kidney, or payment required to obtain written consent to donate a kidney.

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

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

M. Dental Services

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 Services

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

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

      (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 disorders 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.

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

2. Exclusions

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

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

   c. Extraction of impacted teeth, including wisdom teeth..

N. Temporomandibular Joint Dysfunction (TMJ)

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

1. Covered Services

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

2. Exclusions

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

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

O. Diagnostic Services

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

1. Covered Services

   a. Imaging services ordered by a Practitioner, including x-ray, ultrasound, bone density test, 3D mammogram and Advanced Radiological Imaging Services. Advanced Radiological Imaging Services include MRIs, CT scans, PET scans, nuclear medicine and similar technologies.

   b. Diagnostic laboratory services ordered by a Practitioner.

2. Exclusions

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

   b. Diagnostic services not ordered by a Practitioner.

P. Durable Medical Equipment

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

Prior Authorization is required for certain Durable Medical Equipment; if Prior Authorization is not obtained, benefits will be reduced.

1. Covered Services

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

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

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

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

2. Exclusions

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

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

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

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

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

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

g. “Deluxe” or “enhanced” equipment. The most basic equipment that will provide the needed medical care will determine the benefit.

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

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

j. Portable ramp for a wheelchair.

Q. Prosthetics/Orthotics

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

Prior Authorization is required for certain prosthetics/orthotics; if Prior Authorization is not obtained, benefits will be reduced. Hearing aids are not considered to be prosthetics or orthotics; see “Hearing Aid” section for benefits.

1. Covered Services

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

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

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

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

2. The initial purchase of artificial limbs or eyes.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.

R. <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

   a. The initial purchase of Covered Hearing Aids, 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 Aid batteries, cords and other assistive listening devices such as FM systems.

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

S. Diabetes Treatment

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

1. Covered Services

   a. Blood glucose monitors, including monitors designed for the legally blind.

   b. Test strips for blood glucose monitors.

   c. Visual reading and urine test strips.

   d. Insulin.

   e. Injection aids.

   f. Syringes.

   g. Lancets.

   h. Oral hypoglycemic agents.

   i. Glucagon Emergency kits.

j. Injectable incretin mimetics when used in conjunction with selected Prescription Drugs for the treatment of diabetes.

k. Insulin pumps, infusion devices, and appurtenances. Insulin pump replacement is Covered only for pumps older than 48 months and if the pump cannot be repaired.

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

2. Exclusions

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

b. Supplies not required by state statute.

c. Duplicate podiatric appliances.

T. Supplies

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

1. Covered Services

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

b. Supplies for treatment of disease or injury that are prescribed by a Practitioner and cannot be obtained without a Practitioner's Prescription.

2. Exclusions

a. Supplies that can be obtained without a Prescription, except for diabetic supplies. Examples include but are not limited to: (1) adhesive bandages; (2) dressing material for home use; (3) antiseptics; (4) medicated creams and ointments; (5) cotton swabs; and (6) eyewash.

U. Home Health Care Services

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

1. Covered Services

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

b. Home infusion therapy.

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

d. Medical social services.

e. Dietary guidance.

f. Coverage is limited as indicated in "Attachment C: Schedule of Benefits".

2. Exclusions

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

V. Hospice

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

Prior Authorization for inpatient hospice must be obtained or benefits may be reduced or denied.

1. Covered Services

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

2. Exclusions

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

W. Behavioral Health Services

Medically Necessary and Medically Appropriate treatment of mental health and substance use disorders (behavioral health conditions) characterized by abnormal functioning of the mind or emotions and in which psychological, emotional or behavioral disturbances are the dominant features. Behavioral Health includes, but is not limited to, counseling for gender dysphoria and related psychiatric conditions.

Prior Authorization is required for:

- All inpatient levels of care, which include Acute care and residential care.
- Partial hospitalization programs.
- Intensive outpatient treatment programs.
- Certain outpatient Behavioral Health Services including, but not limited to, electro-convulsive therapy (ECT), transcranial magnetic stimulation (TMS) 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 Services

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

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

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

d. Drugs used for substance use disorder administered or dispensed directly by a Practitioner.

e. Counseling (Practitioner visits) for gender dysphoria and related psychiatric conditions (behavioral health conditions).

2. Exclusions

a. Pastoral counseling.

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

c. Vocational and educational training and/or services.

d. Custodial or domiciliary care.

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

f. Sleep disorders.

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

h. Pain management.

i. Hypnosis or regressive hypnotic techniques.

X. Vision

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

1. Covered Services

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

b. Frames, lenses and contacts following treatment and Surgery to repair certain injuries and diseases that impair vision.

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

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

2. Exclusions

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

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

c. Eye exercises and/or therapy.

d. Visual training.

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

Y. Drugs – Medical Coverage

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

1. Covered Services
   a. Treatment of phenylketonuria (PKU), including special dietary formulas while under the supervision of a Practitioner.
   b. Pharmaceuticals that are dispensed or intended for use while You are confined in a hospital, skilled nursing facility or other similar facility.
2. Exclusions
   a. Prescription Drugs except as indicated above.
   b. Those pharmaceuticals that may be purchased without a Prescription.

Z. 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.

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:
      1) dispensed by a licensed pharmacist or dispensing Practitioner on or after the date Your Coverage begins;
      2) approved for use by the Food and Drug Administration (FDA); and
      3) listed on the Preferred Formulary.
   c) Treatment of phenylketonuria (PKU), including special dietary formulas while under the supervision of a Practitioner.
   d) As prescribed for the treatment of diabetes: blood glucose monitors, including monitors designed for the legally blind; test strips for glucose monitoring; visual reading and urine test strips; insulin; injection aids; syringes; lancets; oral hypoglycemic agents; glucagon emergency kits; and injectable incretin mimetics when used in conjunction with selected Prescription Drugs for the treatment of diabetes.
   e) 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) Certain drugs require Step Therapy. When Step Therapy is required, You must initially try a drug that has been proven effective for most people with Your condition. However, if You have already tried an alternate, less expensive drug and it did not work, or if Your doctor believes that You must take the more expensive drug because of Your medical condition, Your doctor can contact the Administrator to request an exception. If the request is approved, the Administrator will Cover the requested drug.

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

i) 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.

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

k) Value-based Pharmacy Benefits Program

Value-based Pharmacy benefits provide a way to help You have access to certain Prescription Drugs You may need to treat a chronic condition. You may have a lower Drug Copayment amount for medications included in the value-based Pharmacy program.

This program Covers the following:

1) Diabetic Supplies

2) Blood Glucose Monitors compatible with formulary test strips

3) Formulary continuous blood glucose monitoring – Dexcom Sensors/Receivers/Transmitters and Freestyle Libre Sensors/Readers

4) Formulary Portable Insulin Delivery Supplies – VGO and Omnipod

Please refer to "Attachment C: Schedule of Benefits" for more information on benefits that apply to these Prescription Drugs.

2. Exclusions

a) Prescription Drugs not on the Drug Formulary - Preferred;

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 doctor's office, except as otherwise Covered in the EOC;

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

e) any Prescription Drug purchased outside the United States, except those Authorized by Us;

f) any Prescription Drug dispensed by or through a non-retail internet Pharmacy;

g) medications intended to terminate a pregnancy;

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

i) artificial appliances;

j) allergen extracts;

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

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 used for substance use disorder administered or dispensed directly by a Practitioner; see the "Behavioral Health Services" section for benefits.

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. Prescription Drugs that represent an advance over available therapy according to the P & T Committee will be reviewed within at least six (6) months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug, will be reviewed within at least twelve (12) months after FDA approval;

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) 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;

u) drugs used to enhance athletic performance;

v) Experimental and/or Investigational Drugs;

w) Prescription Drugs or refills dispensed:

    1) in quantities in excess of amounts specified in the Benefit Payment section;

    2) without Our Prior Authorization when required; or

3) that exceed any applicable annual maximum benefit, or any other maximum benefit amounts stated in the EOC.

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

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 are not Covered, except for syringes used in conjunction with injectable medications or other supplies used in the treatment of diabetes and/or asthma.

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

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

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

AA. Specialty Drugs

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

1. Covered Services

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

   b. Self-administered Specialty Drugs 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. 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.

ATTACHMENT B: OTHER EXCLUSIONS

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

1. Services or supplies not listed as Covered Services under “Attachment A: Covered Services and Exclusions”.
2. Services or supplies that are not Medically Necessary or Medically Appropriate.
3. Services or supplies that are Investigational in nature including, but not limited to: (1) drugs; (2) biologicals; (3) medications; (4) devices; and (5) treatments.
4. Illness or injury resulting from war that occurred before Your Coverage began under this SPD and that is covered by: (1) veteran’s benefit; or (2) other Coverage for which You are legally entitled.
5. Self-treatment or training.
6. Staff consultations required by hospital or other facility rules.
7. Services that are free, except when rendered by a non-governmental, charitable research hospital that bills patients for services rendered but does not enforce collection from an individual patient.
8. Services or supplies for the treatment of work related illness or injury, regardless of the presence or absence of workers’ compensation Coverage.
9. Personal, physical fitness, recreational and convenience items and services such as: (1) barber and beauty services; (2) television; (3) air conditioners; (4) humidifiers; (5) air filters; (6) heaters, (7) physical fitness equipment; (8) saunas; (9) whirlpools; (10) water purifiers; (11) swimming pools; (12) tanning beds; (13) weight loss programs; (14) physical fitness programs; or (15) devices and computers to assist in communication or speech; or (16) self-help devices that are not primarily medical in nature, even if ordered by a Practitioner.
10. Services or supplies received before Your Effective Date for Coverage with this Plan.
11. Services or supplies related to a Hospital Confinement received before Your Effective Date for Coverage with this Plan.
12. Services or supplies received after Your Coverage under this Plan ceases for any reason. This is true even though the expenses relate to a condition that began while You were Covered. The only exception to this is described under the Extended Benefits section.
13. Services or supplies received in a dental or medical department maintained by or on behalf of the Employer, mutual benefit association, labor union or similar group.
14. Services or charges to complete a claim form or to provide medical records or other administrative functions. We will not charge You or Your legal representative for statutorily required copying charges;
15. Charges for failure to keep a scheduled appointment;
16. Charges for telephone consultations, e-mail or web based consultations, except as may be provided for by specially arranged Care Management programs or emerging health care programs, health and wellness programs as described in the “Prior Authorization, Care Management, Medical Policy and Patient Safety” and “Health and Wellness” section of this SPD or in accordance with the Covered Services for

Telehealth in the “Attachment A: Covered Services and Exclusions” section of this SPD;

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: Covered Services and Exclusions” as a non-Covered Service or limitation.
21. Charges for services performed by You or Your spouse, or Your or Your spouse’s parent, sister, brother or child.
22. Any charges for handling fees.
23. Unless Covered under the “Drugs – Prescription Coverage” section, nicotine replacement therapy and aids to smoking cessation including, but not limited to, patches.
24. Human growth hormones.
25. Safety items, or items to affect performance primarily in sports-related activities.
26. Services or supplies related to treatment of complications (except Complications of Pregnancy) that are a direct or closely related result of a Member’s refusal to accept treatment, medicines, or a course of treatment that a Provider has recommended or has been determined to be Medically Necessary, including leaving an inpatient medical facility against the advice of the treating physician.
27. Services considered Cosmetic, except when Medically 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) thighplasty; (8) brachioplasty; (9) keloid removal; (10) dermabrasion; (11) chemical peels; (12) lipectomy; and (13) laser resurfacing.
29. Blepharoplasty and browplasty.
30. Charges relating to surrogate pregnancy when the surrogate mother is not a Covered Member under this Plan.
31. Sperm preservation.
32. Services or supplies for Maintenance Care.
33. Inpatient Private duty nursing.
34. Unless Covered in the “Drugs – Prescription Coverage” section, services or supplies to treat sexual dysfunction, regardless of cause, including but not limited to erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido.

35. Services or supplies related to complications of Cosmetic procedures.

36. Intradiscal annuloplasty to treat discogenic back pain. This procedure provides controlled delivery of heat to the intervertebral disc through an electrode or coil.

37. Methadone and methadone maintenance therapy.

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

39. Travel immunizations not received through Your pharmacy benefit.

ATTACHMENT C: PPO –SCHEDULE OF BENEFITS – SELECT PLAN

Group Name:	City of Memphis
Group Number:	130447
Annual Benefit Period:	1/1/2020
Network:	S (Select Plan)

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

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

	Network Services received from Network Providers	Out-of-Network Services received from Out-of-Network Providers
Maximum	Unlimited	
Deductible [1]		
Individual	$1,500	$3,000
Family	$3,000	$6,000
Out-of-Pocket Maximum [2]		
Individual	$4,000	$8,000
Family	$8,000	$16,000

1. DEDUCTIBLE

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.

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

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

2. OUT-OF-POCKET

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

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

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

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

Member during the remainder of that Annual Benefit Period, excluding applicable Penalties, and any balance of charges (the difference between Billed Charges and the Maximum Allowable Charge).

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Preventive Health Care Services		
Well Child Care (to age 6)	100%	Not Covered
Well Woman Exam	100%	Not Covered
Mammogram, Cervical cancer Screening and Prostate cancer Screening	100%	60% of the Maximum Allowable Charge after Deductible
Immunizations	100%	Not Covered
Preventive/Well Care Services Includes Preventive Health Exam, screenings and counseling services. Tobacco use counseling performed in a primary care setting, limited to 8 visits per Annual Benefit Period; Alcohol misuse counseling performed in a primary care setting, limited to 8 visits per Annual Benefit Period; Dietary counseling for adults with hyperlipidemia, hypertension, obesity, Type 2 diabetes, coronary artery disease and/or congestive heart failure limited to 12 visits per Annual Benefit Period.	100%	Not Covered
Other Well Care Screenings, age 6 and above including flexible sigmoidoscopy or colonoscopy	100%	Not Covered
Lactation counseling by a trained Provider during pregnancy or in the post-partum period.	100%	Not Covered
Manual Breast Pump, limited to one per pregnancy	100%	Not Covered
FDA-approved contraceptive methods, sterilization procedures and counseling for women with reproductive capacity.	100%	Not Covered
One (1) retinopathy screening for diabetics per Annual Benefit Period	100%	Not Covered
Hemoglobin A1C test	100%	Not Covered

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Services Received at the Practitioner's office		
Office Exams and Consultations		
Diagnosis and treatment of illness or injury Primary Care Practitioner types (Internal Medicine, General Practice, Family Medicine, Pediatrics, Obstetrics & Gynecology, Physician Assistant, Nurse Practitioner, Health Department) All other Practitioners The Copayment for a Physician Assistant or Nurse Practitioner may be based on the Provider type of the delegate physician.	100% after $15 Copayment 90% after Deductible	60% of the Maximum Allowable Charge after Deductible
Behavioral Health Services, limited to the first 10 visits per Calendar Year Additional visits for the remainder of the Calendar Year	100% for the first 10 visits, then 100% after $10 Copayment	60% of the Maximum Allowable Charge after Deductible
Maternity care The Copayment applies to the initial office visit to confirm pregnancy. For benefits for subsequent prenatal visits, postnatal visits and the physician delivery charge, see Inpatient Hospital Stays and Behavioral Health Services, in the section Services Received at a Facility. Benefits for specialty care, even if related to pregnancy, are considered as any other illness, and a separate Copayment will apply.	Primary Care Practitioner: 100% after $15 Copayment Specialist: 90% after Deductible	60% of the Maximum Allowable Charge after Deductible
Injections and Immunizations		
Allergy injections and allergy extract	100%	60% of the Maximum Allowable Charge after Deductible
Provider-administered Specialty Drugs	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
All other medicine injections, excluding Specialty Drugs. For Surgery injections, please see Office Surgery under the Other office procedures, services or supplies section.	100%	60% of the Maximum Allowable Charge after Deductible
Diagnostic Services and Preventive Screenings (e.g. x-ray and labwork)		
Allergy Testing	100%	60% of the Maximum Allowable Charge after Deductible

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Services Received at the Practitioner's office		
Advanced Radiological Imaging Includes CT scans, MRIs, PET scans, nuclear medicine and similar technologies. Advanced Radiological Imaging requires Prior Authorization. If Prior Authorization is not obtained benefits may be reduced to 50% for Out-of-Network Providers and to 50% for Network Providers outside Tennessee (BlueCard PPO Providers) (See the Prior Authorization section for more information.) Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization.	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
All Other Diagnostic Services for illness or injury	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
Maternity care diagnostic services	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
Other office procedures, services or supplies		
Office Surgery, including anesthesia, performed in and billed by the Practitioner's office Some procedures require Prior Authorization. Call Our consumer advisors to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, benefits may be reduced to 50% for Out-of-Network Providers and to 50% for Network Providers outside Tennessee (BlueCard PPO Providers), (See the Prior Authorization section for more information.) Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization. Surgeries include incisions, excisions, biopsies, injection treatments, fracture treatments, applications of casts and splints, sutures, and invasive diagnostic services (e.g., colonoscopy, sigmoidoscopy and endoscopy).	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
Non-routine treatments: Includes renal dialysis, radiation therapy, chemotherapy and infusions. Does not apply to Specialty Drugs. Note: Dialysis treatment only Covered at an approved City of Memphis dialysis provider. Out-of-Network dialysis not Covered	90% after Deductible	60% of the Maximum Allowable Charge after Deductible

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Services Received at the Practitioner's office		
All Other Office services	90% after Deductible	60% of the Maximum Allowable Charge after Deductible

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Services Received at a Facility		
Inpatient Hospital Stays and Behavioral Health Services: Inpatient hospital stays (except initial maternity admissions) and Behavioral Health Services require a Prior Authorization. Benefits may be reduced to 50% for a 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.		
Facility charges	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
Inpatient Hospice care	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
Practitioner charges (including global maternity delivery charges billed as inpatient service)	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
Skilled Nursing or Rehab Facility stays (Limited to 70 days per Annual Benefit Period) Prior Authorization required. Benefits may be reduced to 50% for services provided by 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.		
Facility charges	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
Practitioner charges	90% after Deductible	60% of the Maximum Allowable Charge after Deductible

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Services Received at a Facility		
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	$300 Copayment per visit, then 90% after Deductible (Copayment waived if admitted)	$300 Copayment per visit, then 90% of Maximum Allowable Charge (Copayment waived if admitted)
Advanced Radiological Imaging Services Includes CT scans, MRIs, PET scans, nuclear medicine and similar technologies.	90% after Deductible	90% of the Maximum Allowable Charge after Deductible
All Other Hospital Charges	90% after Deductible	90% of the Maximum Allowable Charge after Deductible
Practitioner Charges	90% after Deductible	90% of the Maximum Allowable Charge after Deductible
Outpatient Facility Services including Behavioral Health Intensive Outpatient and Partial Hospitalization Some procedures require Prior Authorization. Call Our consumer advisors to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, benefits may be reduced to 50%for Out-of-Network Providers and to 50% for Network Providers outside Tennessee (BlueCard PPO Providers). (See the Prior Authorization section for more information.) Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization. Surgeries include invasive diagnostic services (e.g., colonoscopy, sigmoidoscopy).		
Facility charges	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
Practitioner charges	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
Outpatient Mental Health Substance Abuse	100% after $10 Copayment	60% of the Maximum Allowable Charge after Deductible

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Services Received at a Facility		
Outpatient Diagnostic Services and Outpatient Screenings		
Advanced Radiological Imaging Includes CT scans, MRIs, PET scans, nuclear medicine and similar technologies. Advanced Radiological Imaging requires Prior Authorization. If Prior Authorization is not obtained, benefits may be reduced to 50% for Out-of-Network Providers and to 50% for Network Providers outside Tennessee (BlueCard PPO Providers). (See the Prior Authorization section for more information. Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization.	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
All other Diagnostic Services for illness or injury	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
Maternity care diagnostic services	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
Other Outpatient Services		
Non-routine treatments: Includes renal dialysis, radiation therapy, chemotherapy and infusions. Does not apply to Specialty Drugs. Note: Dialysis treatment only Covered at an approved City of Memphis dialysis provider. Out-of-Network dialysis not Covered	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
Provider Administered Specialty Drugs	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
All Other services received at an outpatient facility, including chemotherapy, radiation therapy, injections, infusions, and renal dialysis Note: Dialysis treatment only Covered at an approved City of Memphis dialysis provider. Out-of-Network dialysis not Covered	90% after Deductible	60% of the Maximum Allowable Charge after Deductible

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Other Services		
Ground Ambulance	90% of Billed Charges after Deductible	90% of Billed Charges after Deductible
Air Ambulance	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
Urgent Care	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
Home health care services, including home infusion therapy Home health care may require Prior Authorization. Physical, speech or occupational therapy provided in the home do not require Prior Authorization and are subject to the therapy service limits.	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
Outpatient Mental Health/Substance Abuse	$10 Copayment per visit	60% of the Maximum Allowable Charge after Deductible
Outpatient Private Duty Nursing	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
Outpatient Hospice Care	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
Therapy Services: Physical, speech, occupational, cognitive, acupuncture and pulmonary rehab therapy limited to 60 visits combined per Annual Benefit Period Chiropractic Care - limited to 20 visits per Annual Benefit Period	$10 Copayment per visit	60% of the Maximum Allowable Charge after Deductible
Bariatric Surgery and related services	90% after Deductible	Not Covered
DME, Orthotics and Prosthetics	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
Supplies	90% after Deductible	60% of the Maximum Allowable Charge after Deductible

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Other Services – Hearing Aids		
Hearing Aids Limited to one per ear every 3 years (as determined by Your Annual Benefit Period). Members age 18 and over: Limited to $5,000	90% after Deductible	Not Covered

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Other Services – PhysicianNow		
Consultation for medical, dermatology, and counseling services via telephone, tablet or computer. See the "Health and Wellness" section of this SPD for more information.	$0 Copayment per visit	Not Covered

Covered Services	Benefits for Covered Services received from Network Providers		Benefits for Covered Services received from Out-of-Network Providers
Organ Transplant Services			
All Transplant Services, except kidney transplants. All Transplant Services require Prior Authorization. Call Our consumer advisors before any pre-transplant evaluation or other Transplant Service is performed to request Prior Authorization, 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 SPD for more information.	Blue Distinction Centers for Transplants (BDCT) Network: $100 Copayment, then 100% after Network Deductible, Network Out-of-Pocket Maximum applies.	Transplant Network: $100 Copayment, then 90% after Network Deductible, Network Out-of-Pocket Maximum applies.	Out-of-Network Providers: Not Covered
Kidney Transplant Services. All Transplant Services require Prior Authorization. Call Our consumer advisors before any pre-transplant evaluation or other Transplant Service is performed to request Prior Authorization.	$100 Copayment, then 90% after Network Deductible; Network Out-of-Pocket Maximum applies.		Not Covered

Prescription Drugs for Retail Network and Home Delivery Network				
Prescription Drugs	**Generic Drug**	**Preferred Brand Drug**	**Non-Preferred Brand Drug**	**Out-of-Network**
RX04 Retail Network – Up to a 30 day supply	$7 Copay	$30 Copay after Deductible	20% Coinsurance after Deductible with a minimum of $50 and a maximum of $100	50% 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	$7 Copay	$30 Copay after Deductible	20% Coinsurance after Deductible with a minimum of $50 and a maximum of $100	50% of the Maximum Allowable Charge after Deductible
Home Delivery Network and Plus90 Retail Network – For a 31 to 60 day supply	$14 Copay	$60 Copay after Deductible	20% Coinsurance after Deductible with a minimum of $100 and a maximum of $200	50% of the Maximum Allowable Charge after Deductible
Home Delivery Network and Plus90 Retail Network – For a 61 to 90 day supply	$14 Copay	$60 Copay after Deductible	20% Coinsurance after Deductible with a minimum of $100 and a	50% of the Maximum Allowable Charge after Deductible

			maximum of $200	

Value-Based Drugs – Please refer to "Attachment A: Covered Services and Exclusions" for categories of medications that apply to this benefit.				
Prescription Drugs	**Generic Drug**	**Preferred Brand Drug**	**Non-Preferred Brand Drug**	**Out-of-Network**
RX04 Retail Network – Up to a 30 day supply	$0 Copay	$0 Copay	$0 Copay	50% 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	$0 Copay	$0 Copay	$0 Copay	50% of the Maximum Allowable Charge after Deductible
Home Delivery Network and Plus90 Retail Network – For a 31 to 90 day supply	$0 Copay	$0 Copay	$0 Copay	50% 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. If You continue to refill a Prescription outside a Preferred Specialty Pharmacy Network Provider for self-administered Specialty Drugs after the first fill, Your claim will be denied.
Self-administered Specialty Drugs are limited up to a 30 day supply per Prescription.

Self-administered Specialty Drugs	Generic Drug	Preferred Brand Drug	Non-Preferred Brand Drug	Out-of-Network
Preferred Specialty Pharmacy Network	$7 Copay after Deductible	$30 Copay after Deductible	20% Coinsurance after Deductible with a minimum of $50 and a maximum of $100	Not Covered

Additional Provisions

90 day supplies are available through the Home Delivery Network and the Plus90 Retail Network. See bcbst.com to locate network pharmacies and to learn more about the Home Delivery Network.

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

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

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

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

Drug Copayments apply to satisfying any Out-of-Pocket Maximums in the Plan.

ATTACHMENT C: PPO SCHEDULE OF BENEFITS – CHOICE PLAN

Group Name:	City of Memphis
Group Number:	130447
Annual Benefit Period:	1/1/2020
Network:	P (Choice Plan)

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

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

	Network Services received from Network Providers	Out-of-Network Services received from Out-of-Network Providers
Maximum	Unlimited	
Deductible [1]		
Individual	$350	$1,000
Family	$700	$3,000
Out-of-Pocket Maximum [2]		
Individual	$4,000	$4,000
Family	$8,000	$8,000

1. DEDUCTIBLE

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.

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

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

2. OUT-OF-POCKET

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

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

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

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

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Preventive Health Care Services		
Well Child Care (to age 6)	100%	Not Covered
Well Woman Exam	100%	Not Covered
Mammogram, Cervical cancer Screening and Prostate cancer Screening	100%	60% of the Maximum Allowable Charge after Deductible
Immunizations	100%	Not Covered
Preventive/Well Care Services Includes Preventive Health Exam, screenings and counseling services. Tobacco use counseling performed in a primary care setting, limited to 8 visits per Annual Benefit Period; Alcohol misuse counseling performed in a primary care setting, limited to 8 visits per Annual Benefit Period; Dietary counseling for adults with hyperlipidemia, hypertension, obesity, Type 2 diabetes, coronary artery disease and/or congestive heart failure limited to 12 visits per Annual Benefit Period.	100%	Not Covered
Other Well Care Screenings, age 6 and above including flexible sigmoidoscopy or colonoscopy	100%	Not Covered
Lactation counseling by a trained Provider during pregnancy or in the post-partum period.	100%	Not Covered
Manual Breast Pump, limited to one per pregnancy	100%	Not Covered
FDA-approved contraceptive methods, sterilization procedures and counseling for women with reproductive capacity.	100%	Not Covered
One (1) retinopathy screening for diabetics per Annual Benefit Period	100%	Not Covered
Hemoglobin A1C test	100%	Not Covered

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Services Received at the Practitioner's office		
Office Exams and Consultations		
Diagnosis and treatment of illness or injury Primary Care Practitioner types (Internal Medicine, General Practice, Family Medicine, Pediatrics, Obstetrics & Gynecology, Physician Assistant, Nurse Practitioner, Health Department) All other Practitioners The Copayment for a Physician Assistant or Nurse Practitioner may be based on the Provider type of the delegate physician.	100% after $15 Copayment 100% after $30 Copayment	60% of the Maximum Allowable Charge after Deductible
Behavioral Health Services, limited to the first 10 visits per Calendar Year Additional visits for the remainder of the Calendar Year	100% for the first 10 visits, then 100% after $10 Copayment	60% of the Maximum Allowable Charge after Deductible
Maternity care The Copayment applies to the initial office visit to confirm pregnancy. For benefits for subsequent prenatal visits, postnatal visits and the physician delivery charge, see Inpatient Hospital Stays and Behavioral Health Services, in the section Services Received at a Facility. Benefits for specialty care, even if related to pregnancy, are considered as any other illness, and a separate Copayment will apply.	Primary Care Practitioner: 100% after $15 Copayment Specialist: 100% after $30 Copayment	60% of the Maximum Allowable Charge after Deductible
Injections and Immunizations		
Allergy injections and allergy extract	100%	60% of the Maximum Allowable Charge after Deductible
Provider-administered Specialty Drugs	100%	Not Covered
All other medicine injections, excluding Specialty Drugs. For Surgery injections, please see Office Surgery under the Other office procedures, services or supplies section.	100%	60% of the Maximum Allowable Charge after Deductible
Diagnostic Services and Preventive Screenings (e.g. x-ray and labwork)		
Allergy Testing	100%	60% of the Maximum Allowable Charge after Deductible

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Services Received at the Practitioner's office		
Advanced Radiological Imaging Includes CT scans, MRIs, PET scans, nuclear medicine and similar technologies. Advanced Radiological Imaging requires Prior Authorization. If Prior Authorization is not obtained, benefits may be reduced to 50% for Out-of-Network Providers and to 50% for Network Providers outside Tennessee (BlueCard PPO Providers). (See the Prior Authorization section for more information.) Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization.	Primary Care Practitioner: 100% after $15 Copayment Specialist: 100% after $30 Copayment	60% of the Maximum Allowable Charge after Deductible
All Other Diagnostic Services for illness or injury	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
Maternity care diagnostic services	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
Other office procedures, services or supplies		
Office Surgery, including anesthesia, performed in and billed by the Practitioner's office Primary Care Practitioner types All other Practitioners The Copayment for a Physician Assistant or Nurse Practitioner may be based on the Provider type of the delegate physician. Some procedures require Prior Authorization. Call Our consumer advisors to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, benefits may be reduced to 50% for Out-of-Network Providers and to 50% for Network Providers outside Tennessee (BlueCard PPO Providers). (See the Prior Authorization section for more information.) Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization. Surgeries include incisions, excisions, biopsies, injection treatments, fracture treatments, applications of casts and splints, sutures, and invasive diagnostic services (e.g., colonoscopy, sigmoidoscopy and endoscopy).	100% after $15 Copayment per visit 100% after $30 Copayment per visit	60% of the Maximum Allowable Charge after Deductible

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Services Received at the Practitioner's office		
Non-routine treatments: Includes renal dialysis, radiation therapy, chemotherapy and infusions. Does not apply to Specialty Drugs. Note: Dialysis treatment only Covered at an approved City of Memphis dialysis provider. Out-of-Network dialysis not Covered	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
All Other Office services	90% after Deductible	60% of the Maximum Allowable Charge after Deductible

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Services Received at a Facility		
Inpatient Hospital Stay and Behavioral Health Services: Inpatient hospital stays (except initial maternity 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.		
Facility charges	90% after Deductible	$300 Copayment per admission, then 60% of the Maximum Allowable Charge after Deductible
Inpatient Hospice care	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
Practitioner charges (including global maternity delivery charges billed as inpatient service)	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
Skilled Nursing or Rehab Facility stays (Limited to 70 days per Annual Benefit Period) Prior Authorization required. 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.		
Facility charges	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
Practitioner charges	90% 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.		

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Services Received at a Facility		
Emergency Room charges	$300 Copayment per visit, then 90% after Deductible (Copayment waived if admitted)	$300 Copayment per visit, then 90% after Deductible (Copayment waived if admitted)
Advanced Radiological Imaging Services Includes CT scans, MRIs, PET scans, nuclear medicine and similar technologies.	90% after Deductible	90% of the Maximum Allowable Charge after Deductible
All Other Hospital Charges	90% after Deductible	90% of the Maximum Allowable Charge after Deductible
Practitioner Charges	90% after Deductible	90% of the Maximum Allowable Charge after Deductible
Outpatient Facility Services including Behavioral Health Intensive Outpatient and Partial Hospitalization Some procedures require Prior Authorization. Call Our consumer advisors to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, benefits may be reduced to 50% for Out-of-Network Providers and to 50% for Network Providers outside Tennessee (BlueCard PPO Providers). (See the Prior Authorization section for more information.) Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization. Surgeries include invasive diagnostic services (e.g., colonoscopy, sigmoidoscopy).		
Facility charges	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
Practitioner charges	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
Outpatient Mental Health Substance Abuse	100% after $10 Copayment	60% of the Maximum Allowable Charge after Deductible

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Services Received at a Facility		
Outpatient Diagnostic Services and Outpatient Screenings		
Advanced Radiological Imaging Includes CT scans, MRIs, PET scans, nuclear medicine and similar technologies. Advanced Radiological Imaging requires Prior Authorization. If Prior Authorization is not obtained, benefits may be reduced to 50% for Out-of-Network Providers and to 50% for Network Providers outside Tennessee (BlueCard PPO Providers). (See the Prior Authorization section for more information.) Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization.	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
All other Diagnostic Services for illness or injury	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
Maternity care diagnostic services	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
Other Outpatient Services		
Non-routine treatments: Includes renal dialysis, radiation therapy, chemotherapy and infusions. Does not apply to Specialty Drugs. Note: Dialysis treatment only Covered at an approved City of Memphis dialysis provider. Out-of-Network dialysis not Covered	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
Provider-Administered Specialty Drugs	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
All Other services received at an outpatient facility, including chemotherapy, radiation therapy, injections, infusions, and renal dialysis Note: Dialysis treatment only Covered at an approved City of Memphis dialysis provider. Out-of-Network dialysis not Covered	90% after Deductible	60% of the Maximum Allowable Charge after Deductible

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Other Services		
Ambulance	90% of Billed Charges after Deductible	90% of Billed Charges after Deductible
Air Ambulance	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
Urgent Care	$50 Copayment per visit	$50 Copayment, then 60% of the Maximum Allowable Charge after Deductible
Home health care services, including home infusion therapy Home health care may require Prior Authorization. Physical, speech or occupational therapy provided in the home do not require Prior Authorization and are subject to the therapy service limits.	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
Outpatient Mental Health/Substance Abuse	$10 Copayment per visit	60% of the Maximum Allowable Charge after Deductible
Outpatient Private Duty Nursing	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
Outpatient Hospice Care	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
Therapy Services: Physical, speech, occupational, cognitive, acupuncture and pulmonary rehab therapy limited to 60 visits combined per Annual Benefit Period	$10 Copayment per visit	60% of the Maximum Allowable Charge after Deductible
Chiropractic Care - limited to 20 visits per Annual Benefit Period	$10 Copayment per visit	Not Covered
Evaluation and Testing of Infertility	90% after Deductible	60% of the Maximum Allowable Charge after Deductible
DME, Orthotics and Prosthetics	90% after Deductible	Not Covered
Supplies	90% after Deductible	60% of the Maximum Allowable Charge after Deductible

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Other Services – Hearing Aids		
Hearing Aids for Members under age 18 Limited to one per ear every 3 years (as determined by Your Annual Benefit Period). Members age 18 and over: Limited to $5,000	90% after Deductible	Not Covered

Covered Services	Benefits for Covered Services received from Network Providers	Benefits for Covered Services received from Out-of-Network Providers
Other Services – PhysicianNow		
Consultation for medical, dermatology and counseling services via telephone, tablet or computer. See the "Health and Wellness" section of this SPD for more information.	$0 Copayment per visit	Not Covered

Covered Services	Benefits for Covered Services received from Network Providers		Benefits for Covered Services received from Out-of-Network Providers
Organ Transplant Services			
All Transplant Services, except kidney transplants. All Transplant Services require Prior Authorization. Call Our consumer advisors before any pre-transplant evaluation or other Transplant Service is performed to request Prior Authorization, 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 SPD for more information.	Blue Distinction Centers for Transplants (BDCT) Network: $200 Copayment, then 100% after Network Deductible, Network Out-of-Pocket Maximum applies.	Transplant Network: $200 Copayment, then 90% after Network Deductible, Network Out-of-Pocket Maximum applies.	Not Covered
Kidney Transplant Services. All Transplant Services require Prior Authorization. Call Our consumer advisors before any pre-transplant evaluation or other Transplant Service is performed to request Prior Authorization.	$200 Copayment, then 90% after Network Deductible; Network Out-of-Pocket Maximum applies.		Not Covered

Prescription Drugs for Retail Network and Home Delivery Network				
Prescription Drugs	**Generic Drug**	**Preferred Brand Drug**	**Non-Preferred Brand Drug**	**Out-of-Network**
RX04Retail Network – Up to a 30 day supply	$7 Copay	$30 Copay after Deductible	$50 Copay after Deductible	50% 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	$7 Copay	$30 Copay after Deductible	$50 Copay after Deductible	50% of the Maximum Allowable Charge after Deductible
Home Delivery Network and Plus90 Retail Network – For a 31 to 60 day supply	$14 Copay	$60 Copay after Deductible	$100 Copay after Deductible	50% of the Maximum Allowable Charge after Deductible
Home Delivery Network and Plus90 Retail Network – For a 61 to 90 day supply	$14 Copay	$60 Copay after Deductible	$100 Copay after Deductible	50% of the Maximum Allowable Charge after Deductible

Value-Based Drugs – Please refer to "Attachment A: Covered Services and Exclusions" for categories of medications that apply to this benefit.				
Prescription Drugs	**Generic Drug**	**Preferred Brand Drug**	**Non-Preferred Brand Drug**	**Out-of-Network**
RX04 Retail Network – Up to a 30 day supply	$0 Copay	$0 Copay	$0 Copay	50% 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	$0 Copay	$0 Copay	$0 Copay	50% of the Maximum Allowable Charge after Deductible
Home Delivery Network and Plus90 Retail Network – For a 31 to 90 day supply	$0 Copay	$0 Copay	$0 Copay	50% 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. If You continue to refill a Prescription outside a Preferred Specialty Pharmacy Network Provider for self-administered Specialty Drugs after the first fill, Your claim will be denied.				
Self-administered Specialty Drugs are limited up to a 30 day supply per Prescription.				
Self-administered Specialty Drugs	**Generic Drug**	**Preferred Brand Drug**	**Non-Preferred Brand Drug**	**Out-of-Network**
Preferred Specialty Pharmacy Network	$7 Copay after Deductible	$30 Copay after Deductible	$50 Copay after Deductible	Not Covered

Additional Provisions

90 day supplies are available through the Home Delivery Network and the Plus90 Retail Network. See bcbst.com to locate network pharmacies and to learn more about the Home Delivery Network.

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

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

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

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

Drug Copayments apply to satisfying any Out-of-Pocket Maximums in the Plan.

PLAN IDENTIFICATION

Plan Name:	City of Memphis
Name and Address of Plan Administrator:	City of Memphis 2714 Union Extended 4th Floor Memphis, TN 38112
Employer's Tax ID Number:	62-6000361
Plan Number:	N/A
Group Number:	130447
Agent for Legal Process:	City of Memphis Legal
Claim Administrator	BlueCross BlueShield of Tennessee, Inc. 1 Cameron Hill Circle 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, 2020
Type of Plan:	Employee Welfare Benefit Plan
Plan Cost:	Employees: Contributory 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.

GENERAL LEGAL PROVISIONS

INDEPENDENT LICENSEE OF THE BLUE CROSS BLUE SHIELD ASSOCIATION

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

RELATIONSHIP WITH NETWORK PROVIDERS

A. Independent Contractors

Network Providers are 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 Employer 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 Employer, as the Plan Administrator as that term is defined in ERISA, has the discretionary authority to make the final determination regarding the terms of Your Coverage ("Coverage Decisions.") Both the Administrator and the Employer make Coverage Decisions based on the terms of this SPD, the ASA, the Administrator's internal guidelines, policies, procedures, and applicable State or Federal laws. The Employer retains the authority to determine whether You or Your dependents are eligible for Coverage.

You may request reconsideration of a Coverage Decision as explained in the Grievance Procedure section of this SPD. 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 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 Copayment, Coinsurance, 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.

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

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Patients who undergo a mastectomy and who elect breast reconstruction in connection with the mastectomy in a manner determined in consultation with the attending physician and patient 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 lymphedemas

The Coverage will be provided subject to the same Coinsurance, Copays and Deductibles established for other benefits under this Plan. Please refer to the Covered Services section of this SPD for details.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

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

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 or underinsured 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 any party 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 Employer, deems necessary to protect the Plan's rights under this section.

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

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

Legal Action and Costs

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

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 immediately 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 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.

NOTICE OF PRIVACY PRACTICES

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

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

LEGAL OBLIGATIONS

Employer is required to maintain the privacy of all health plan information, which may include Your: name, address, diagnosis codes, etc. as required by applicable laws and regulations (hereafter referred to as "Legal Obligations"); provide this notice of privacy practices to all Members, inform Members of the Employer's Legal Obligations; and advise Members of additional rights concerning their health plan information. Employer must follow the privacy practices contained in this notice from its Effective Date until this notice is changed or replaced.

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

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

ORGANIZATIONS COVERED BY THIS NOTICE

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

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

USES AND DISCLOSURES OF YOUR INFORMATION

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

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

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

4. **AUTHORIZATIONS:** You may provide written Authorization to use Your health plan information or to disclose it to anyone for any purpose. You may revoke Your Authorization in writing at any time. That revocation will not affect any use or disclosure permitted by Your Authorization while it was in effect. Employer cannot use or disclose Your health plan information except as described in this notice, without Your written Authorization. Examples of where an Authorization would be required include: most uses and disclosures of psychotherapy notes (if recorded by a covered entity), uses and disclosures for marketing purposes, disclosures that constitute a sale of protected health information (PHI), other uses and disclosures not described in this notice.

5. **PERSONAL REPRESENTATIVE:** Your health plan information may be disclosed to a family member, friend or other person as necessary to help with Your health care or with Payment for Your health care. You must agree that the Employer may do so, as described in the Individual Rights section of this notice.

6. **PLAN SPONSORS:** Your health plan information, and the health plan information of others enrolled in Your group health plan, may be disclosed to Your plan sponsor in order to perform plan administration functions. Please see Your plan documents for a full description of the uses and disclosures the plan sponsor may make of Your health plan information in such circumstances.

7. **UNDERWRITING:** Your health plan information may be received for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a health insurance or benefits contract. If the Employer does not issue that contract, Your health plan information will not be used or further disclosed for any other purpose, except as required by law. Additionally, health plans are prohibited from using or disclosing genetic information of an individual for underwriting purposes pursuant to the Genetic Information Nondiscrimination Act of 2008 (GINA).

8. **MARKETING:** Your health plan information may be used to provide information about health-related benefits, services or treatment alternatives that may be of interest to You. Your health plan information may be disclosed to a business associate assisting us in providing that information to You. We will not market products or services other than health-related products or services to You unless You affirmatively opt-in to receive information about non-health products or services We may be offering. You have the right to opt out of fundraising communications.

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

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

11. **AS REQUIRED BY LAW:** Your health plan information may be used or disclosed as required by state or federal law.

12. **COURT OR ADMINISTRATIVE ORDER:** Health plan information may be disclosed in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances.

13. **VICTIM OF ABUSE:** If You are reasonably believed to be a victim of abuse, neglect, domestic violence or other crimes, health plan information may be released to the extent necessary to avert a serious threat to Your health or safety or to the health or safety of others. Health plan information may be disclosed, when necessary, to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

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

INDIVIDUAL RIGHTS

1. **DESIGNATED RECORD SET:** You have the right to look at or get copies of Your health plan information, with limited exceptions. You must make a written request, using a form available from the Privacy Office, to obtain access to Your health plan information. If You request copies of Your health plan information, You will be charged 25¢ per page, $10 per hour for staff time required to copy that information, and postage if You want the copies mailed to You. If You request an alternative format, the charge will be based upon the cost of providing Your health plan information in the requested format. If You prefer, the Employer will prepare a summary or explanation of Your health plan information for a fee. For a more detailed explanation of the fee structure, please contact the Privacy Office. Employer requires advance Payment before copying Your health plan information.

2. **ACCOUNTING OF DISCLOSURES:** You have the right to receive an accounting of any disclosures of Your health plan information made by the Employer or a business associate for any reason, other than treatment, Payment, or health care operations purposes within the past six years. This accounting will include the date the disclosure was made, the name of the person or entity the disclosure was made to, a description of the health plan information disclosed, the reason for the disclosure, and certain other information. If You request an accounting more than once in a 12-month period, there may be a reasonable cost-based charge for responding to those additional requests. Please contact the Privacy Office for a more detailed explanation of the fees charged for such accountings.

3. **RESTRICTION REQUESTS:** You have the right to request restrictions on the Employer's use or disclosure of Your health plan information. Employer is not required to agree to such requests. Employer will only restrict the use or disclosure of Your health plan information as set forth in a written agreement that is signed by a representative of the Privacy Office on behalf of the Employer.

4. **BREACH NOTICE:** You have the right to notice following a breach of unsecured protected health information. The notice of a breach of unsecured protected health information shall at a minimum include the following: The date of the breach, the type of data disclosed in the breach, who made the non-permitted access, use or disclosure of unsecured protected health information and who received the non-permitted disclosure, and what corrective business action was or will be taken to prevent further non-permitted access, uses or disclosures of unsecured protected health information.

5. **CONFIDENTIAL COMMUNICATIONS:** If You reasonably believe that sending health plan information to You in the normal manner will endanger You, You have the right to make a written request that the Employer communicate that information to You by a

different method or to a different address. If there is an immediate threat, You may make that request by calling the Employer. Follow up with a written request is required as soon as possible. Employer must accommodate Your request if it: is reasonable, specifies how and where to communicate with You, and continues to permit collection of premium and Payment of claims under Your health plan.

6. **AMENDMENT REQUESTS:** You have the right to make a written request that the Employer amend Your health plan information. Your request must explain why the information should be amended. Employer may deny Your request if the health plan information You seek to amend was not created by the Employer or for other reasons permitted by its Legal Obligations. If Your request is denied, the Employer will provide a written explanation of the denial. If You disagree, You may submit a written statement that will be included with Your health plan information. If the Employer accepts Your request, reasonable efforts will be made to inform the people that You designate about that amendment. Any future disclosures of that information will be amended.

7. **RIGHT TO REQUEST WRITTEN NOTICE:** If You receive this notice on the Employer's web site or by electronic mail (e-mail), You may request a written copy of this notice by contacting the Privacy Office.

QUESTIONS AND COMPLAINTS

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

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

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

The Privacy Office

City of Memphis.

2714 Union Extended, 5th Floor, Suite 100

Memphis TN, 38112

901-576-6403