

Vanderbilt Group Health Plan for Faculty and Staff

BlueCross Advantage P Option



**BlueCross BlueShield
of Tennessee**

NOTICE

Please read this evidence of coverage carefully and keep it in a safe place for future reference. It explains your Vanderbilt Network benefits as administered by BlueCross BlueShield of Tennessee, Inc. If you have any questions about this evidence of coverage or any other matter related to your membership in the plan, please write or call us at:

**CUSTOMER SERVICE DEPARTMENT
BLUECROSS BLUESHIELD OF TENNESSEE, INC.,
ADMINISTRATOR
801 PINE ST.
CHATTANOOGA, TENNESSEE 37402-2555
(800) 565-9140**

NOTE: Neither the Plan nor Vanderbilt in its capacity of Plan Sponsor provides or ensures the quality of care. Members always have the choice of what services they receive and who provides their health care, regardless of what the Plan covers or pays.

In the event that any provision in this Evidence of Coverage conflicts with the Vanderbilt Health Care Plan Document, the plan document will govern.

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INTRODUCTION

The "Plan" means any arrangement which provides benefits or services for, or because of, medical or dental care or treatment through group, blanket, or franchise insurance (whether insured or uninsured) other than school accident-type coverage. This Plan refers to the part of the employee welfare benefit plan under which benefits for health care expenses are provided.

This Evidence of Health Coverage (this "EOC") together with the Vanderbilt Health Care Summary Plan Description forms the complete Summary Plan Description document (SPD) for the Vanderbilt Network Option. References in this EOC to "administrator," "We," "Us," "Our," or "BCBST" mean BlueCross BlueShield of Tennessee, Inc. The Employer has entered into an Administrative Services Agreement (ASA) with BCBST for it to administer the claims payments under the terms of the SPD, and to provide other services. BCBST 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. Other federal laws may also affect Your Coverage. To the extent applicable, the Plan complies with federal requirements.

Together with the Vanderbilt Health Care Summary Plan Document, this EOC describes the terms and conditions of Your Coverage through the Plan. These replace and supersede any Certificate or other description of benefits You have previously received from the Plan.

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

NON-COVERED BENEFIT. (SEE ATTACHMENTS A-D.)

While the Employer has delegated discretionary authority to make any benefit or eligibility determinations to the administrator, the Employer also has the authority to make any final Plan determination. The Employer, as the Plan Administrator, and BCBST also have the authority to construe the terms of Your Coverage. The Plan and BCBST shall be deemed to have properly exercised that authority unless it abuses its discretion when making such determinations.

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

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

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

INDEPENDENT LICENSEE OF THE BLUECROSS BLUESHIELD ASSOCIATION

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

PHARMACY BENEFITS ARE NOT COVERED THROUGH BCBST. PLEASE CONTACT VANDERBILT HUMAN RESOURCE CUSTOMER SERVICE AT (615) 322-8330 or HR.Vanderbilt.edu/Benefits.

ELIGIBILITY

All full-time faculty and full-time regular exempt staff are eligible for Coverage immediately. All other full-time regular Employees are eligible 90 days after the first day of employment. For Employees returning to Vanderbilt, within the specified time frame under the bridging policy (HR-007), eligibility is immediate. In the case of an Employee who acquires a dependent after becoming eligible for Coverage, the dependent is eligible on the date acquired. For staff moving from regular part-time status to regular full-time status, service while in the regular part-time status counts toward the waiting period for eligibility.

Eligible Dependents

1. Your spouse or certified domestic partner. (Certified domestic partner is a person of the same sex that is not related by blood. The partner must not be under 21 years of age, not legally married to anyone else, nor have another domestic partner. This person must be currently in a committed relationship of six months or more duration and reside in a common household sharing joint responsibility for the household with the Employee. Certification of domestic partnership must be obtained through the Office of the Director of Benefits, Human Resources.)
2. Your unmarried children from birth to 25 years of age. Children must live with You in a regular parent-child relationship, or reside in a custodial institution for medical reasons or another monitored environment (endorsed by a physician on an annual basis) for medical or behavioral reasons, and depend upon You for more than 70 percent of their support. If a court approved "Qualified Medical Child Support Order" is provided within 31 days of the date issued, the requirement that the child reside with the Employee will be waived. They must be children of the Employee by birth, legal guardianship or custody, legal adoption or placement in anticipation of adoption, the Employee's stepchildren, or the children of the Employee's certified domestic partner.
3. Any unmarried children 25 years of age or older who are incapable of self-support because of mental or physical disability, if the disability existed, and is documented with Vanderbilt's Office of Benefits Administration, prior to their reaching the age of 25. Children must live with

You in a regular parent-child relationship, or reside in a custodial institution for medical reasons or reside in another monitored environment (endorsed by a physician on an annual basis) for medical or behavioral reasons, and depend upon You for more than 70 percent of their support. They must be children of the employee by birth, legal guardianship or custody, legal adoption or placement in anticipation of adoption, the Employee's stepchildren, or the children of the Employee's certified domestic partner. The Plan Administrator or its designee must approve the continuation of Coverage for this child. The University reserves the right to audit dependents and may require copies of any legal papers issued to establish a person as Your dependent. Only copies of actual court documents issued by the respective courts will be considered as acceptable documentation.

RELATIONSHIP WITH NETWORK PROVIDERS

A. Independent Contractors

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

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

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

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

B. Termination of Providers’ Participation

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

C. Provider Directory

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

NOTIFICATION OF CHANGE IN STATUS

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

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

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

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

**TERMINATION OR MODIFICATION OF
COVERAGE**

A. Termination or Modification of Coverage

Vanderbilt University may modify or terminate the Plan at any time.

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

If the Plan pays for Covered Services you receive 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.

SUBROGATION AND RIGHT OF RECOVERY

Subrogation Rights

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

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

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

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

Priority Right of Reimbursement

Separate and apart from the Plan's right of subrogation, the Plan shall have first lien and right to reimbursement. This priority right of reimbursement supersedes Your right to be made whole from any recovery, whether full or partial. You agree to reimburse the Plan 100% first for any and all benefits provided through the Plan, and for any costs of recovering such amounts from those third parties from any and all amounts recovered through:

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

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

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

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

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

Notice and Cooperation

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

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

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

Legal Action and Costs

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

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

Settlement or Other Compromise

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

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

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

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

BLUECARD/BLUECARD PPO PROGRAM

When You are in an area where Our Network Providers are not available and You need health care services or information about a BlueCross BlueShield PPO physician or hospital, just call the BlueCard/BlueCard PPO Participating Doctor and Hospital Information Line at 1-800-810-BLUE (2583.)

We will help You locate the nearest BlueCard/BlueCard PPO Participating Provider.

If You call 1-800-810-BLUE (2583), **and** go to a BlueCard/BlueCard PPO Participating Physician or Hospital, Your benefits will be Covered as In-network benefits, and Your out-of-pocket expenses will be less than if You go to a non- BlueCard/BlueCard PPO Participating Provider or Hospital.

In the BlueCard/BlueCard PPO Program, the term “Host Plan” means the BlueCross BlueShield Plan that provides access to service in the location where You need health care services.

Show Your membership ID card (that has the “PPO in a suitcase” logo) to any BlueCard/BlueCard PPO Participating Provider. The BlueCard/BlueCard PPO Participating Provider can verify Your membership, eligibility and Coverage with Your BlueCross BlueShield Plan. When You visit a BlueCard/BlueCard PPO Participating Provider, You should not have claim forms to file. After You receive services, Your claim is electronically routed to BCBST, which processes it and sends You a detailed explanation of benefits. You are responsible for any applicable Copayments, or Your Deductible and Coinsurance payments (if any.)

The calculation of Your liability for claims incurred outside Our service area which are processed through the BlueCard/BlueCard PPO Program will typically be at the lower of the provider's Billed Charges or the negotiated price We pay the Host Plan.

The negotiated price We pay to the Host Plan for health care services provided through the BlueCard/BlueCard PPO Program may represent either: (a) the actual price paid by the Host Plan on such claims; (b) an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the Host Plan's health care Providers or one or more particular Providers; or (c) a discount from Billed Charges representing the Host Plan's expected average savings for all of its Providers or for a specified group of Providers. The discount that reflects average savings may result in

greater variation (more or less) from the actual price paid than will the estimated price.

Plans using either the estimated price or average savings factor methods may prospectively adjust the estimated or average price to correct for over- or underestimation of past prices. However, the amount You pay is considered a final price.

In addition, laws in certain states may require BlueCross and/or BlueShield Plans to use a basis for calculating Member liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Thus, if You receive Covered Services in these states, Your liability for Covered Services will be calculated using these states' statutory methods.

REMEMBER: YOU ARE RESPONSIBLE FOR RECEIVING PRIOR AUTHORIZATION FROM US. IF PRIOR AUTHORIZATION IS NOT RECEIVED, YOUR BENEFITS MAY BE REDUCED OR DENIED. CALL THE 1-800 NUMBER ON YOUR MEMBERSHIP ID CARD FOR PRIOR AUTHORIZATION. IN CASE OF AN EMERGENCY, YOU SHOULD SEEK IMMEDIATE CARE FROM THE CLOSEST HEALTH CARE PROVIDER.

BLUECARD

If You don't have BLUECARD PPO (Your membership card doesn't have the “PPO in a suitcase” logo), You can go to any BlueCard Participating Provider, and receive the same level of benefits.

BLUECARD WORLDWIDE

Through the BlueCard Worldwide Program, You also have access to a participating hospital network and referrals to doctors in major travel destinations throughout the world. When You need to locate a hospital or doctor, You can call the BlueCard Worldwide Service Center at 1.800.810.BLUE, or call collect at 1.804.673.1177, 24 hours a day, 7 days a week. You can also visit the web site <https://international.worldaccess.com/bcbsa/index.asp?page=login>, or You can call BCBST. When You need inpatient medical care, call the BlueCard Worldwide Service Center, who will refer You to a participating hospital. You will only be responsible for the Plan's usual out-of-pocket expense (i.e., non-covered expenses, deductible, copayment and/or coinsurance). In an emergency, You should go to the nearest hospital and call the BlueCard Worldwide Service Center if You are admitted. You still have the choice of using non-BlueCard Worldwide

hospitals; however, You may have to pay the hospital directly and then file a claim for reimbursement. Your out-of-pocket expenses may be significantly higher. The BlueCard Worldwide Service Center will also provide referrals to doctors, but You will have to pay the provider and then file the claim for reimbursement.

CLAIMS AND PAYMENT

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

A. Claims.

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

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

B. Claims Billing.

1. You should not be billed or charged for Covered Services rendered by Network Providers, except for required Member payments. The Network Provider will submit the claim directly to Us.
2. You may be charged or billed by an Out-of-Network Provider for Covered Services rendered by that Provider. If You use an Out-of-Network Provider, You are responsible for the difference between Billed Charges and the Maximum Allowable Charge for a Covered Service. You are also responsible for complying with any of the

Plan's medical management policies or procedures (including, obtaining Prior Authorization of such Services, when necessary).

- a. If You are charged, or receive a bill, You must submit a claim to Us.
 - b. To be reimbursed, You must submit the claim within 1 year and 90 days from the date a Covered Service was received. If You do not submit a claim, within the 1 year and 90 day time period, it will not be paid. If it is not reasonably possible to submit the claim within the 1 year and 90 day time period, the claim will not be invalidated or reduced.
3. Not all Covered Services are available from Network Providers. There may be some Provider types that We do not contract with. These Providers are called Non-Contracted Providers. Claims for services received from Non-Contracted Providers are handled as described in section 2.a. and b. above. You are also responsible for complying with any of the Plan's medical management policies or procedures (including, obtaining Prior Authorization of such Services, when necessary).
 4. You may request a claim form from Our customer service department. We will send You a claim form within 15 days. You must submit proof of payment acceptable to Us with the claim form. We may also request additional information or documentation if it is reasonably necessary to make a Coverage decision concerning a claim.
 5. A Network Provider, or an Out-of-Network Provider may refuse to render, or reduce or terminate a service that has been rendered, or require You to pay for what You believe should be a Covered Service. If this occurs:
 - a. You may submit a claim to Us to obtain a Coverage decision concerning whether the Plan will Cover that service. For example, if a pharmacy (1) does not provide You with a prescribed medication; or (2) requires You to pay for that prescription, You may submit a claim to the Plan to obtain a Coverage decision about whether it is Covered by the Plan.
 - b. You may request a claim form from Our customer service department. We will

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

C. Payment.

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

6. When a claim is paid or denied, in whole or part, You will receive an Explanation of Benefits (EOB). This will describe how much was paid to the Provider, and also let You know if You owe an additional amount to that Provider. The administrator will send the EOB to the last address on file for You.
7. You are responsible for paying any applicable Copayments, Coinsurance, or Deductible amounts to the Provider.

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

D. Complete Information.

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

Mail all claim forms to:

BCBST Claims Service Center
PO Box 180150
Chattanooga, Tennessee 37401-7150

PRIOR AUTHORIZATION, CARE MANAGEMENT, MEDICAL POLICY AND PATIENT SAFETY

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

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

A. Prior Authorization

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

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

- Inpatient Hospital stays (except maternity admissions)
- Skilled nursing facility and rehabilitation facility admissions
- Certain Outpatient Surgeries and/or procedures
- Certain Specialty Drugs
- Certain Prescription Drugs (if Covered by a prescription drug card)
- Advanced Radiological Imaging services
- Other services not listed at the time of printing may be added to the list of services that require Prior Authorization. Notice of changes to the Prior Authorization list will be made via Our Web site and the Member newsletter. You may also call Our customer service department at the phone number on Your ID card to find out which services require Prior Authorization.

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

Network Providers in Tennessee will request Prior Authorization for You.

You are responsible for requesting Prior Authorization when using Providers outside Tennessee and Out-of-Network Providers, or benefits will be reduced or denied.

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

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

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

The Member is not held harmless if:

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

If You use an Out-of-Network Provider, or a Provider outside Tennessee, such as a Blue Card PPO Participating Provider, You are responsible for ensuring that the Provider obtains the appropriate Authorization prior to treatment. Failure to obtain the necessary Authorization may result in additional Member Payments and reduced Plan payment. Contact Our customer service department for a list of Covered Services that require Prior Authorization.

B. Care Management

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

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

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

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

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

In that event, alternative benefits for services not otherwise specified as Covered Services in Attachment A may be offered to the Member. Such benefits shall not exceed the Lifetime Maximum specified or the total amount of benefits under this EOC, and will be offered only in accordance with a written case management or alternative treatment plan agreed to by the Member's attending physician and BCBST.

Emerging Health Care Programs -- Care Management is continually evaluating emerging health care programs. These are services or technologies that demonstrate reasonable

potential improvement in access, quality, health care costs, efficiency, and Member satisfaction. When We approve an emerging health care program, services provided through that program are Covered, even though they may normally be excluded under the EOC.

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

C. Medical Policy

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

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

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

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

D. Patient Safety

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

CONTINUATION OF COVERAGE

Federal Law

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

1. Eligibility

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

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

2. 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:

- a. The Subscriber’s termination of employment, reduction in hours

worked, death or entitlement to Medicare coverage; or

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

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

3. 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.

4. Coverage Provided

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

5. Duration of Eligibility for COBRA Continuation Coverage

COBRA Continuation Coverage is available for a maximum of:

- a. 18 months if the loss of Coverage is caused by termination of employment or reduction in hours of employment; or
- b. 29 months of Coverage. If, as a qualified beneficiary who has elected 18 months of COBRA Continuation Coverage, You are determined to be disabled within the first 60 days of COBRA Continuation Coverage, You can extend Your COBRA Continuation Coverage for an additional 11 months, up to 29 months. Also, the 29 months of COBRA Continuation Coverage is available to all non-disabled qualified beneficiaries in connection with the same qualifying event. "Disabled" means disabled as determined under Title II or XVI of the Social Security Act. In addition, the disabled qualified beneficiary or any other non-disabled qualified beneficiary affected by the termination of employment qualifying event must.
 - (1) Notify the Employer or the administrator of the disability determination within 60 days after the determination of disability, and before the close

of the initial 18-month Coverage period; and

- (2) Notify the Employer or the administrator within 30 days of the date of a final determination that the qualified beneficiary is no longer disabled; or
 - c. 36 months of Coverage if the loss of Coverage is caused by:
 - (1) the death of the Subscriber;
 - (2) loss of dependent child status under the Plan;
 - (3) the Subscriber becomes entitled to Medicare; or
 - (4) divorce or legal separation from the Subscriber; or
 - d. 36 months for other qualifying events. If a Covered Dependent is eligible for 18 months of COBRA Continuation Coverage as described above, and there is a second qualifying event (e.g., divorce), You may be eligible for 36 months of COBRA Continuation Coverage from the date of the first qualifying event.
6. Termination of COBRA Continuation Coverage
- After You have elected COBRA Continuation Coverage, that Coverage will terminate either at the end of the applicable 18, 29 or 36 month eligibility period or, before the end of that period, upon the date that:
- a. The Payment for such Coverage is not submitted when due; or
 - b. You become Covered as either a Subscriber or dependent by another group health care plan, and that coverage is as good as or better than the COBRA Continuation Coverage; or
 - c. The ASA is terminated; or
 - d. You become entitled to Medicare Coverage; or
 - e. The date that You, otherwise eligible for 29 months of COBRA Continuation Coverage, are

determined to no longer be disabled for purposes of the COBRA law.

7. Continued Coverage During a Leave of Absence

Federal law requires that the Employer allow Subscribers to continue their Coverage during a leave of absence. Please check with the human resources department to find out how long Subscribers may take a leave of absence.

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

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

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

8. 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.

MAINTENANCE OF BENEFITS

A. Purpose of Coordination of Benefits

If another Payor provides coverage to You, the Plan may coordinate its benefits with those of that other Payor (the "Primary Plan"). The Plan will follow the "Maintenance of Benefits" alternative set forth in chapter 0780-1-53 of the Tennessee Regulations (the "State COB Regulations") to coordinate benefits when it is the secondary Plan.

When the Plan is secondary (meaning it determines its benefits after another Plan), its benefits plus those of the Primary Plan will be less than 100% of Allowable Expenses unless the Primary Plan, by itself, provides benefits at 100% of Allowable Expenses. When services are provided by a Participating Provider, you will not be required to pay more than \$2,000 for any Covered person in any Calendar Year toward the expenses or services Covered under this Plan for which the Plan is the Secondary Plan pursuant to this provision.

B. Information About Coverage From Other Payors

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

C. Group Coordination of Benefits

The Plan shall coordinate benefits as follows:

1. Applicability
 - a. This coordination of benefits (COB) provision applies when You have health care coverage under more than 1 plan.
 - b. If this COB provision applies, the order of benefit determination rules is applied. Those rules determine whether the Plan's benefits are determined before or after those of another plan. The Plan's benefits:
 - (1) Shall not be reduced when, under the order of benefit determination rules, the Plan determines its

benefits before another plan (i.e. is the Primary Plan); but

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

2. Definition of Terms Used in this Section

- a. A "Plan" provides benefits or services for medical or dental care or treatment, from:
 - (1) Group insurance or group-type coverage, whether insured or uninsured. This includes health maintenance, prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
 - (2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state Medicaid Plan (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act).
- b. Primary Plan and Secondary Plan. The order of benefit determination rules state whether this Plan is a Primary Plan or secondary Plan as to another Plan covering the person. When this Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits. When this Plan is a secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits. When there are more than 2 Plans covering the person, this Plan may be a Primary Plan as to 1 or more other Plans and may be a secondary Plan as to a different Plan(s).
- c. Allowable Expense means a necessary, reasonable and customary item of expense for health care, when that expense is Covered at least in part by 1 or more Plans covering the person for whom the claim is made. When a Plan provides benefits in the form of services,

the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid. When benefits are reduced under a Primary Plan because a Covered person does not comply with the Plan provisions, the amount of that reduction will not be considered an Allowable Expense.

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

3. Order of Benefit Determination Rules

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

- (1) The other Plan has rules coordinating its benefits with those of this Plan; and
- (2) Both those rules and this Plan's rules, set forth below, require that this Plan's benefits be determined before those of the other Plan.

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

- (1) Nondependent/dependent. The benefits of the Plan which 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;
- (2) Dependent child/parents not separated or divorced. Except as stated in paragraph 3(b) 3, when this Plan and another Plan cover the same child as a dependent of different parents:
 - (a) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but
 - (b) If both parents have the same birthday, the benefits of the Plan which Covered 1 parent longer

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

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

- (a) First, the Plan of the parent with custody of the child;
- (b) Then, the Plan of the spouse of the parent with the custody of the child; and
- (c) Finally, the Plan of the parent not having custody of the child. However, if the specific terms of a court decree state that 1 of the parents is responsible for the health care expense of the child, and the Plan that is obligated to pay or provide benefits to that child under that decree has actual knowledge of those terms, the benefits of that Plan are determined first.

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

- (5) Active/inactive Employee. The benefits of a Plan which 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. The same would be true if a person is a dependent of a person Covered as a retiree and an Employee. If the

other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule (5) is ignored.

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

4. Effect On the Benefits Of This Plan

- a. When This Section Applies. This section 4 applies when, in accordance with the Order of Benefit Determination Rules, this Plan is a secondary Plan as to 1 or more other Plans (the "Other Plans"). In that event, the benefits of this Plan may be reduced under this section.
- b. Reduction in this Plan's benefits.
- (1) The benefits that would be payable for the allowable expenses under this Plan in the absence of this COB provision will be reduced by the benefits payable under the other Plans for the expenses Covered in whole or in part under this Plan. This applies whether or not claim is made under a Plan.
- (2) When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both the expense incurred and the benefit payable.
- (3) When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

5. Right To Receive And Release Needed Information

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

give the Plan any facts it needs to pay the claim.

6. Facility of Payment

A payment made under Other Plans may include an amount which should have been paid under this Plan. If it does, the Plan may pay that amount to the Other Plan that made that payment. That amount will then be treated as though it were a benefit paid under this Plan, which will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

7. Right of Recovery

If the amount of the payments made by the Plan is more than it should have paid under this COB provision, it may recover the excess from 1 or more of:

- a. The person it has paid or for whom it has made such payment;
- b. Other plans; or
- c. Other organizations.

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

D. Subscribers and Covered Dependents Enrolled for Medicare

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

GRIEVANCE PROCEDURE

I. INTRODUCTION

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

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

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

- a. If a Provider does not render, or reduces or terminates a service that has been rendered, or requires You to pay for what You believe should be a Covered Service, You may submit a Claim to the Plan to obtain a determination concerning whether the Plan will cover that service. As an example, if a pharmacy does not provide You with a prescribed medication or requires You to pay for that prescription, You may submit a Claim to the Plan to obtain a determination about whether it is Covered by the Plan. Providers may be required to hold You harmless for the cost of services in some circumstances.
 - b. Providers may also appeal an Adverse Benefit Determination through the Plan's Provider dispute resolution procedure.
 - c. A Plan determination will not be an Adverse Benefit Determination if: (1) a Provider is required to hold You harmless for the cost of services rendered; or (2) until the Plan has rendered a final Adverse Benefit Determination in a matter being appealed through the Provider dispute resolution procedure.
5. You may request a form from the Plan to authorize another person to act on Your behalf concerning a Dispute.
 6. The Plan and You may agree to skip one or more of the steps of this Procedure if it will not help to resolve the Dispute.
 7. Any Dispute will be resolved in accordance with applicable Tennessee or Federal laws and regulations, the ASA and this EOC.

II. DESCRIPTION OF THE REVIEW PROCEDURES

A. Inquiry

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

B. Grievance

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

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

1. Grievance Hearing

After the Plan has 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, the Plan will appoint one or more qualified reviewer(s) to consider such Grievances. Individuals involved in making prior determinations concerning Your Dispute are not eligible to be voting members of the first level Grievance committee or reviewers. The Committee or reviewers have full discretionary authority to make eligibility, benefit and/or claim determinations, pursuant to the ASA. Such determinations shall be subject to the review standards applicable to ERISA plans, even if the ASA is not otherwise governed by ERISA.

2. Written Decision

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

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

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

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

- (a) A statement of the committee's understanding of Your Grievance;
- (b) The basis of the committee's decision; and
- (c) Reference to the documentation or information upon which the committee based its decision. The Plan will send You a copy of such documentation or information, without charge, upon written request.

C. Next Level Grievance Procedure

If You are not satisfied, and Your ASA is governed by ERISA, You also have the right to bring a civil action against the Plan to obtain the remedies available pursuant to Sec. 502(a) of ERISA ("ERISA Actions") after completing the mandatory first level Grievance process.

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

If You disagree with the decision of the first level Grievance committee and the Plan has any additional levels of Grievance hearings available, Plan personnel will provide You with the appropriate information.

GENERAL DEFINITIONS

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

1. **Actively At Work** – The performance of all of an Employee’s regular duties for the Employer on a regularly scheduled workday at the location where such duties are normally performed. Eligible Employees will be considered to be Actively At Work on a non-scheduled work day (which would include a scheduled vacation day) only if the Employee was Actively At Work on the last regularly scheduled workday. An eligible Employee who is not at work due to a health-related factor shall be treated as Actively At Work for purposes of determining Eligibility.
2. **Administrative Services Agreement or ASA** – The arrangements between the administrator and the Employer, including any amendments, and any attachments to the ASA or this EOC.
3. **Acute** - That an illness or injury is both severe and of short duration.
4. **Ambulatory Surgical Facility** - a health care facility which provides surgical services but usually does not have overnight accommodations; has an organized staff of Physicians and permanent facilities and equipment; and is not used primarily as an office or clinic for a Physician or other professional private practice.

Such a facility must be licensed as an Ambulatory Surgical Facility by the state in which it is located or must be operated by a Hospital licensed by the state in which it is located.
5. **Behavioral Health Services** – Any services or supplies that are Medically Necessary and Appropriate to treat: a mental or nervous condition; alcoholism; chemical dependence; drug abuse or drug addiction.
6. **Billed Charges** – The amount that a Provider charges for Services rendered. Billed Charges may be different from the amount that BCBST determines to be the Maximum Allowable Charge for Services.
7. **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.

8. **Calendar Year** - The period of time beginning at 12:01 A.M. on January 1st and ending 12:00 A.M. on December 31st of the year in which Coverage is effective.
9. **Care Management** – A program that promotes quality and cost effective coordination of care for Members with complicated medical needs, chronic illnesses, and/or catastrophic illnesses or injuries.
10. **Coinsurance** - The amount, stated as a percentage of the Maximum Allowable Charge for a Covered Service that is the responsibility of the Member during the Calendar Year after any Deductible is satisfied. The Coinsurance percentage is as specified in the Schedule of Benefits (Attachment C).

The Member shall be responsible for the difference between the Billed Charges and the Maximum Allowable Charge for a Covered Service 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.
11. **Complications of Pregnancy** – Conditions requiring Hospital Confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, non-elective caesarian section, ectopic pregnancy which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

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

12. **Concurrent Review Process** – The process of evaluating care that continues past the period initially approved by the administrator.
13. **Contracted Transplant Network Institution** -- is one which has contracted with the administrator (or with an entity on behalf of the administrator) to provide facility Transplant Services for the organ and bone marrow transplant procedures Covered under this EOC. (A list of Contracted Transplant Institutions is available from BCBST upon request by the Employer or the Member.)
14. **Copayment**– The dollar amount specified in Attachment C, Schedule of Benefits, that Members are required to pay directly to a Provider for certain Covered Services. Members must pay such Copayments at the time they receive those Services.
15. **Cosmetic Surgery** – Any treatment intended to alter or improve appearance but which does not restore or improve impaired physical function, as determined by Us.
16. **Covered Dependent** - A Subscriber's family member who meets the eligibility requirements of the Plan, has been enrolled for Coverage and for whom the Plan has received the applicable payment for Coverage.
17. **Covered Family Members** – A Subscriber and his or her Covered Dependents.
18. **Covered Services, Coverage or Covered** - Those Medically Necessary and Appropriate services and supplies that are set forth in Attachment A of this EOC, (which is incorporated by reference). Covered Services are subject to all the terms, conditions, exclusions and limitations of the Plan and this EOC.
19. **Creditable Coverage** – Credit for Your individual or group health coverage prior to Your Enrollment Date which may be applied to reduce Your Pre-existing Condition Waiting Period, if any, stated in this EOC. Creditable Coverage also includes coverage under: (1) COBRA; (2) a health maintenance organization (HMO); (3) Medicare; (4) Medicaid (including TennCareSM or other state exempted plans); (5) the Federal Employee Health Benefit Plan; and/or (6) a public, government, military or Indian Health Service health benefit program.
- Up to 18 months of Creditable Coverage may be applied to reduce Your applicable Pre-existing Condition Waiting Period. However, a period of coverage will not be counted for purposes of reducing Your Pre-existing Condition Waiting Period if there is a break in such coverage of 63 days or more during which You were not Covered under any Creditable Coverage.
20. **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.
21. **Deductible** - The dollar amount, specified in Attachment C, Schedule of Benefits, which a Member must incur and pay for Covered Services during a Calendar Year before BCBST provides benefits for such services. There are two separate Deductibles – one for services rendered by Participating Providers, and one for services rendered by Non-Participating Providers. The Deductible will not apply to the applicable Out-of-Pocket and Family Out-of-Pocket Maximum(s). Neither Copayments nor any balance of charges (between Billed Charges and the Maximum Allowable Charge) required for Covered Services rendered by a Non-Participating Provider will be considered when determining if the Member has satisfied a Deductible. Dollar amounts incurred during the last 3 months of a Calendar Year that are applied to the Deductible during that Calendar Year will also apply to the Deductible for the next Calendar Year.
22. **Emergency** – A sudden and unexpected medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect to result in:
- serious impairment of bodily functions; or
 - serious dysfunction of any bodily organ or part; or

- 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.

- 23. **Emergency Care Services** - Those services and supplies that are Medically Necessary and Appropriate in the treatment of an Emergency.
- 24. **Employee** – An individual currently or formerly employed by the Employer who fulfills all the eligibility requirements of the Plan as defined in the Vanderbilt University Health Care Summary Plan Description.
- 25. **Employer** – Vanderbilt University and any affiliated organizations as designated in the Vanderbilt University Group Health Plan Summary Plan Description.
- 26. **Enrollment Form** – A form or application, which must be completed in full by the Eligible Employee before he/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.
- 27. **ERISA** - The Employee Retirement Income Security Act of 1974, as amended.
- 28. **Family Deductible** - The maximum dollar amount, specified in Attachment C, Schedule of Benefits, that a Subscriber and Covered Dependents must incur and pay for Covered Services during a Calendar Year before the Plan provides benefits for such Services. There are two separate Family Deductibles – one for services rendered by Network Providers, and one for services rendered by Out-of-Network Providers. Once the Family Deductible –Network Provider amount has been satisfied by 2 or more Covered Family Members during a Calendar Year, the Deductible –Network Provider will be considered satisfied for all Covered Family Members for the remainder of that Calendar Year. Once the Family Deductible – Out-of-Network Provider amount has been satisfied by 2 or more Covered Family Members during a Calendar Year, the Deductible – Out-of-Network Provider will be considered satisfied for all Covered Family Members for the remainder of that Calendar Year. Dollar amounts incurred during the last 3 months of a Calendar Year that are applied to the

Deductible during that Calendar Year will also apply to the Deductible for the next Calendar Year.

- 29. **Family Out of Pocket Maximum** – The total dollar amount of Coinsurance, as stated in the Schedule of Benefits (Attachment C) which a Subscriber and Covered Dependents must incur and pay for Covered Services during the Calendar Year. In Network P, there are two separate Family Out of Pocket Maximums – one for services rendered by Network Providers, and one for services rendered by Out-of-Network Providers.

Coinsurance payments for Covered Services rendered by an Out-of-Network Provider will apply only to determining if the “Family Out of Pocket Maximum – Out-of-Network Providers” has been met. Copayments, Penalties, and any balance of charges (the difference between Billed Charges and the Maximum Allowable Charge) will not apply in determining if the Family Out-of-Pocket Maximum has been met.

Coinsurance payments for Covered Services rendered by a Network Provider will apply only to determining if the “Family Out of Pocket Maximum - Network Providers” has been met. Copayments, Penalties, and any balance of charges (the difference between Billed Charges and the Maximum Allowable Charge) will not apply in determining if the Family Out-of-Pocket Maximum has been met. Coinsurance payments for Covered Services You receive through the BlueCard program will apply toward Your “Family Out of Pocket Maximum –Network Providers.”

When the “Family Out of Pocket Maximum –Network Providers” is satisfied, the Plan pays 100% for other Covered Services to which Coinsurance would otherwise apply for all Covered Family Members during the remainder of that Calendar Year for Covered Services received from Network Providers. The Member will still have to pay any applicable Copayments and Penalties.

When the “Family Out of Pocket Maximum – Out-of-Network Providers” is satisfied, the Plan pays 100% for other Covered Services to which Coinsurance would otherwise apply for all Covered Family Members during the remainder of that Calendar Year for Covered Services received from Out-of-Network

Providers. The Member will still have to pay any applicable Copayments and Penalties, and any balance of charges (between Billed Charges and the Maximum Allowable Charge).

30. **Hospital** - a facility that:

- a. Operates pursuant to law;
- b. Provides 24-hour nursing services by a registered nurse (RN) on duty or call;
- c. Has a staff of one or more Physicians at all times; and
- d. Provides organized facilities and equipment for diagnosis and treatment of Acute medical, surgical or mental/nervous conditions either on its premises or in facilities available to it on a pre-arranged basis.

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

31. **Hospital Confinement or Hospital Admission**

– When a Member is treated as a registered bed patient at a Hospital or other Provider facility and incurs a room and board charge.

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

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

34. **Investigational Services** – A drug, device, treatment, therapy, procedure, or other service or supply that does not meet the definition of Medical Necessity or:

- a. cannot be lawfully marketed without the approval of the Food and Drug Administration (“FDA”) when such approval has not been granted at that time of its use or proposed use, or

- b. is the subject of a current Investigational new drug or new device application on file with the FDA, or
- c. is being provided according to Phase I or Phase II clinical trial or the experimental or research portion of a Phase III clinical trial (provided, however, that participation in a clinical trial shall not be the sole basis for denial), or
- d. is being provided according to a written protocol which describes among its objectives, determining the safety, toxicity, efficacy or effectiveness of that service or supply in comparison with conventional alternatives, or
- e. is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (“IRB”) as required and defined by Federal regulations, particularly those of the FDA or the Department of Health and Human Services (“HHS,”) or
- f. in the predominant opinion of experts, as expressed in the published authoritative literature, that usage should be substantially confined to research settings, or
- g. in the predominant opinion of experts, as expressed in the published authoritative literature, further research is necessary in order to define safety, toxicity, efficacy, or effectiveness of that Service compared with conventional alternatives, or
- h. the service or supply is required to treat a complication of an experimental or Investigational Service.

The Medical Director has discretionary authority, in accordance with applicable ERISA standards, 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:

- (1) Your medical records, or

- (2) the protocol(s) under which proposed service or supply is to be delivered, or
- (3) any consent document that You have executed or will be asked to execute, in order to receive the proposed service or supply, or
- (4) 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
- (5) regulations and other official publications issued by the FDA and HHS, or
- (6) the opinions of any entities that contract with the Plan to assess and coordinate the treatment of Members requiring non-Investigational Services, or
- (7) the findings of the BlueCross and BlueShield Association Technology Evaluation Center or other similar qualified evaluation entities.

The Medical Director's decision may be appealed to the Employer, which has final authority on any decision affecting the Plan.

- 35. **Lifetime Maximum** – The maximum amount that the Plan will pay for Covered Services rendered to a Member during his or her lifetime.
- 36. **Maximum Allowable Charge** – The amount that the Plan, at its sole discretion, has determined to be the maximum amount payable for a Covered Service. That determination will be based upon the administrator's contract with a Network Provider or the amount payable based on the administrator's fee schedule for the Covered Services rendered by Out-of-Network Providers.
- 37. **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 programs.
- 38. **Medically Appropriate** – services which have been determined by the Medical Director to be of value in the care of a

specific Member. To be Medically Appropriate a service must:

- a. be Medically Necessary.
 - b. be used to diagnose or treat a Member's condition caused by disease, injury or congenital malformation.
 - c. be consistent with current standards of good medical practice for the Member's medical condition.
 - d. be provided in the most appropriate site and at the most appropriate level of service for the Member's medical condition.
 - e. on an ongoing basis, have a reasonable probability of:
 - (1) correcting a significant congenital malformation or disfigurement caused by disease or injury;
 - (2) preventing significant malformation or disease; or.
 - (3) substantially improving a life sustaining bodily function impaired by disease or injury.
 - f. not be provided solely to improve a Member's condition beyond normal variations in individual development and aging including:
 - (1) comfort measures in the absence of disease or injury.
 - (2) improving physical appearance that is within normal individual variation.
 - g. not be for the sole convenience of the Provider, Member or Member's family.
39. **Medically Necessary or Medical Necessity** – "Medically Necessary" means procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:
- in accordance with generally accepted standards of medical practice; and
 - clinically appropriate in terms of type, frequency, extent, site and duration and

considered effective for the patient's illness, injury or disease; and

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

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

40. **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.
41. **Mental Health/Substance Abuse or MHSA Services** - Any services or supplies that are Medically Necessary and Appropriate to treat: a mental or nervous condition; alcoholism; chemical dependence, abuse or drug addiction.
42. **Network Provider** – A Provider who has contracted with the administrator to provide access to benefits to Members at specified rates. Such Providers may be referred to as BlueCard PPO Participating Providers, Participating Hospitals, In-Transplant Network , etc.
43. **Non-Contracted Provider** – A Provider that renders Covered Services to a Member, in the situation where We have not contracted with that Provider type to provide those Covered Services. These Providers can change, as We contract with different Providers. A Provider's status as a Non-Contracted Provider, Network Provider, or Out-of-Network Provider can and does change. We reserve the right to change a Provider's status.

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

45. **Out-of-Pocket Maximum** - The total dollar amount of Coinsurance, as stated in the Schedule of Benefits (Attachment C) which a Member must incur and pay for Covered Services during the Calendar Year. In Network P, there are two separate Out-of-Pocket Maximums – one for services rendered by Network Providers, and one for services rendered by Out-of-Network Providers.

Coinsurance payments for Covered Services rendered by an Out-of-Network Provider, will apply only to determining if the "Out-of-Pocket Maximum – Out-of-Network Providers" has been met.

When the "Out-of-Pocket Maximum – Network Providers" is satisfied, the Plan pays 100% for other Covered Services to which Coinsurance would otherwise apply for the Member during the remainder of that Calendar Year for Covered Services received from Network Providers. The Member will still have to pay any applicable Deductible and Penalties. Coinsurance payments for any Covered Services You receive through the BlueCard program will apply toward Your "Out-of-Pocket Maximum –Network Providers."

When the "Out-of-Pocket Maximum – Out-of-Network Providers" is satisfied, the Plan pays 100% for other Covered Services to which Coinsurance would otherwise apply for the Member during the remainder of that Calendar Year for Covered Services received from Out-of-Network Providers. The Member will still have to pay any applicable Copayments and Penalties, and any balance of charges (between Billed Charges and the Maximum Allowable Charge).

46. **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.
47. **Penalty/Penalties** – Additional Member payments required as a result of failure to comply with Plan requirements such as failing to obtain Prior Authorization for certain Covered Services listed in the Schedule of Benefits, Attachment C, as

- requiring such Prior Authorization. The Penalty will be a reduction in the Plan payment for Covered Services.
48. **Periodic Health Screening** – An interval assessment of patient’s health status for the purpose of maintaining health and detecting disease in its early state. This assessment should include:
- a complete history or interval update of the patient’s history and a review of systems,
 - a physical examination of all major organ systems, and preventive screening tests per the United States Preventive Services Task Force on Preventive Care and the administrator’s Medical Policy.
49. **Practitioner** – A person licensed by the State to provide medical services.
50. **Prescription Drug** – A medication containing at least one Legend Drug which may not be dispensed under applicable state or federal law without a Prescription, and/or insulin.
51. **Prior Authorization** – A review conducted by the administrator, prior to the delivery of certain services, to determine if such services will be considered Covered Services.
52. **Provider** – A person or entity that is engaged in the delivery of health services who or that is licensed, certified or practicing in accordance with applicable State or Federal laws.
53. **Qualified Medical Child Support Order** – A medical child support order, issued by a court of competent jurisdiction or state administrative agency, which creates or recognizes the existence of a child’s right to receive benefits for which a Subscriber is eligible under the Plan. Such order shall identify the Subscriber and each such child by name and last known mailing address; give a description of the type and duration of coverage to be provided to each child; and identify each health plan to which such order applies.
54. **Skilled Nursing Facility** - provides convalescent and rehabilitative care on an Inpatient basis. Skilled nursing care must be provided by or under the supervision of a Physician. Neither
- a facility which primarily provides minimal, custodial, ambulatory, or part time care, nor
 - a facility which treats mental illness, alcoholism, drug abuse, or pulmonary tuberculosis
- will be considered a Skilled Nursing Facility under this plan.
55. **Subscriber** – An Employee who meets all applicable eligibility requirements, has enrolled for Coverage and who has submitted the applicable payment for Coverage.
56. **Totally Disabled or Total Disability** - Either:
- because of injury or disease, that You, if an Employee, are prevented from performing Your work duties and are unable to engage in any work or other gainful activity for which You are qualified or could reasonably become qualified to perform by reason of education, training, or experience; or
 - because of non-occupational injury or disease, that You, if a Covered Dependent, are prevented from engaging in substantially all of the normal activities of a person of like age and sex in good health.
57. **Transplant Maximum Allowable Charge (TMAC)** – The amount that the administrator, in its sole discretion, has determined to be the maximum amount payable for covered Services for Organ Transplants. Each type of Organ Transplant has a separate TMAC.
58. **Transplant Services** – Medically Necessary and Appropriate services listed as Covered under the Transplant Services section in Attachment A of this EOC.
59. **Well Child Care** – A routine visit to a pediatrician or other qualified Practitioner which includes Medically Appropriate Periodic Health Screenings, immunizations and injections for children up to the age of 6 years.
60. **Well Care Exam** – A routine physical examination every Calendar Year for children over age 6 and adults. The visit may include Medically Appropriate childhood and adult immunizations.

EVIDENCE OF COVERAGE

ATTACHMENT A: COVERED SERVICES AND LIMITATIONS ON COVERED SERVICES

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

To be eligible for reimbursement or payment, all services or supplies must be provided in accordance with the administrator’s Medical Management Policies and Procedures. (See Medical Management Section.)

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

- Eligible Providers, and
- Eligible services.

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

Your Plan covers Pre-existing Conditions, and does not impose a Pre-existing Condition Waiting Period.

I. ELIGIBLE PROVIDERS OF SERVICE

A. Practitioners

To be Covered, services must be rendered by a Practitioner within his or her specialty or degree. All services must: be rendered by the Practitioner or his delegate actually billing for them and be within the scope of his or her licensure. To receive the highest level of benefits, Members should receive services from a Network Provider.

B. Network Provider

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

C. Vanderbilt Medical Group

The Vanderbilt Medical Group includes the Vanderbilt Medical Center or a Vanderbilt Medical Group affiliated Provider.

D. Out-of-Network Provider

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

E. Other Providers of Service

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

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II. ELIGIBLE SERVICES:

A. Practitioner Office Services

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

1. Covered
 - a. Office surgery.
 - b. Rehabilitative therapies.
 - c. Prostate screenings.
 - d. Injections and inoculations.
 - e. Allergy care including basic testing, evaluations, serum and injections.
 - f. Casts and dressings.
 - g. Nutritional guidance and education.
 - h. Foot care and orthotics necessary to prevent the complications of an existing disease state.
 - i. Pre and post-natal maternity care.
 - j. Second surgical opinions.
 - k. Services and supplies for the diagnosis and treatment of illness or injury.
 - l. Services and supplies for the diagnosis and treatment of illness or injury relating to hearing, speech, voice or language other than for a functional nervous disorder.
 - m. Emergency Medical Condition conditions presented to the Practitioner's Office.
2. Limitations/Exclusions
 - a. Office visits and physical exams for school, camp, employment, travel, insurance, marriage or legal proceedings and related immunizations and tests are not Covered.
 - b. Second surgical opinions must be given by a Practitioner who is not in the same medical group as the Practitioner who initially recommended the surgery.
 - c. Routine foot care for the treatment of flat feet, corns, bunions, calluses, toenails, fallen arches, weak feet or chronic foot strain are not Covered.
 - d. Rehabilitative therapies are subject to the limitations of the Therapeutic/ Rehabilitative benefit.

B. Preventive Services

Medically Necessary and Appropriate services for assessing physical status and detecting abnormalities.

1. Covered
 - a. Routine visits including hearing screenings, history and physical exam, height and weight for infants to age 24 months.
 - b. Well Child Care to age 6 including vision and hearing screenings, immunizations and other appropriate diagnostics.
 - c. Well Care Exams, subject to the limit listed in Attachment C, Schedule of Benefits.
 - d. Routine visits including assessment, routine testing, patient education, history and physical exam, prostate-specific antigen (PSA), Papanicolaou smear (Pap test) for cervical cancer screening, mammogram, influenza vaccination and colonoscopy for adults (age 19-64 years).
 - e. Periodic colorectal cancer screening, not subject to the Calendar Year maximum benefit limit.
2. Limitations/Exclusions
 - a. Four office visits between ages 2-6 years for routine periodic health assessment.
 - b. Office visit every other year for ages 7-10 years for routine periodic health assessment.
 - c. Office visit every year for ages 11-18 years for routine periodic health assessment.
 - d. Services not recommended by the guidelines from United States Task Force on Preventive Care and the Plan's Medical Policy are not Covered.

C. Inpatient Hospital Services

Medically Necessary and Appropriate services and supplies in a Hospital which: is a licensed Acute care institution; which provides inpatient services and has surgical and medical facilities primarily for the diagnosis and treatment of a disease and injury; has a staff of Physicians licensed to practice medicine and provides 24 hour nursing care by graduate registered nurses.

psychiatric Hospitals are not required to have a surgical facility.

1. Covered

- a. Room, board, and general nursing care in a
 - semi-private room,
 - private room (limited to most common semi-private room rate, unless approved by BCBST),
 - Special Care Unit as approved by BCBST;

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

- b. Drugs and medicines, including take home drugs.
- c. Use of operating, delivery and treatment rooms;
- d. Maternity and delivery services, including Complications of Pregnancy.
- e. Sterile dressings, casts, splints and crutches.
- f. Special diets.
- g. Diagnostic services (x-ray and laboratory and certain other tests).
- h. Anesthetics.
- i. Certain therapy services.
- j. Blood and the administration of whole blood
- k. 23-hour observation rooms.
- l. Attending Practitioner's services for professional care, including treatment of eating disorders and Gastric By-Pass surgery for morbid obesity.

2. Limitations/Exclusions

- a. Inpatient stays primarily for therapy (such as physical or occupational therapy) are not Covered.
- b. Private duty nursing is not Covered.
- c. Services that could be provided in a less intensive setting are not Covered.

- d. Services must be ordered, provided, or authorized by Your Physician.
- e. Private room is Covered only when authorized by the administrator.
- f. Prior Authorization must be obtained from the administrator for services, or benefits will be denied or reduced.
- g. Blood/plasma is Covered unless free.

D. Outpatient Facility Services

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

1. Covered

- a. Practitioner services.
- b. Outpatient diagnostics (such as x-rays and laboratory services), treatments (such as medications and injections.)
- c. Outpatient surgery and supplies.

2. Limitations/Exclusions

- a. Rehabilitative therapies are subject to the terms of the Therapeutic/ Rehabilitative benefit.
- b. Services that could be provided in a less intensive setting are not Covered.

E. Hospital Emergency Care Services

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

1. Covered

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

2. Limitations/Exclusions

- a. Emergency Care does not include treatment of a chronic condition in which sub-acute symptoms have existed over a period of time and would not be

considered an Emergency unless symptoms suddenly became severe enough to require immediate medical assistance.

- b. Once the Member's medical condition has stabilized, Prior Authorization must be obtained from the administrator for inpatient care or transfer to another facility. Benefits will be denied or reduced if such authorization is not obtained within 24 hours or the next working day.

F. Home Health Services

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

- 1. Covered
 - a. Part-time, intermittent health services, supplies and medications, by or under the supervision of a registered nurse.
 - b. Home infusion therapy.
 - c. Rehabilitative therapies such as physical therapy, occupational therapy, etc. (subject to the limitations of the Therapeutic/Rehabilitative benefit).
 - d. Medical social services.
 - e. Dietary guidance.
- 2. Limitations/Exclusions
 - a. Items such as routine transportation, homemaker or housekeeping services, behavioral counseling, supportive environmental equipment, maintenance or Custodial Care, social casework, meal delivery, personal hygiene and convenience items are not Covered.
 - b. Services are limited to 60 visits per Calendar Year.
 - c. Prior Authorization must be obtained from the administrator for services.

G. Hospice

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

- 1. Covered

- a. Benefits will be provided for part-time intermittent nursing care, medical social services, bereavement counseling, medications for the control or palliation of the illness, home health aide services, physical or respiratory therapy for symptom control.

2. Limitations/Exclusions

- a. Services such as homemaker or housekeeping services, meals, convenience or comfort items not related to the illness, supportive environmental equipment, private duty nursing, routine transportation, funeral or financial counseling are not Covered.
- b. Services such as Practitioner visits, inpatient and outpatient care, ambulance, chemotherapy, radiation therapy, enteral and parenteral feeding, home hemodialysis, psychiatric care may be Covered under the terms found elsewhere in the EOC.
- c. Prior Authorization must be obtained from the administrator for services.

H. Skilled Nursing/Rehabilitative Facility Services

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

1. Covered

- a. Room and board in a semi-private room; general nursing care; medications, diagnostics and special care units.
- b. The attending Practitioner's services for professional care.

2. Limitations/Exclusions

- a. Coverage will be limited to a total of 60 days per Calendar Year.
- b. Custodial, domiciliary or private duty nursing services are not Covered.
- c. Skilled Nursing services must be in a Medicare certified skilled nursing facility.

- d. Prior Authorization must be obtained from the administrator for services or benefits will be denied or reduced.

I. Ambulance Services

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

1. Covered
 - a. Medically Necessary and Appropriate land transportation from the scene of an accident or Emergency to the nearest appropriate facility. Air ambulance transportation is covered only in life threatening situations where Medically Necessary.
2. Limitations/Exclusions
 - a. Transportation for the sole convenience of the Member.
 - b. Transportation that is not essential to reduce the probability of harm to the patient.
 - c. Transfers between facilities must receive Prior Authorization from the administrator.
3. Benefits will be available for Medical Evacuation back to a Member's home country and for repatriation of the remains of a deceased employee to the home country for resident aliens.

J. Family Planning and Reproductive Services

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

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

2. Limitations/Exclusions

- a. Benefits for any services or supplies that are designed to medically enhance a Member's level of fertility in the absence of a disease state are not Covered.
- b. Assisted Reproductive Technology (ART), such as GIFT, ZIFT, in vitro fertilization and fertility drugs are not Covered.
- c. Sterilization reversal.
- d. Elective Abortions.
- e. Those medications intended to terminate a pregnancy (e.g. RU-486).

K. Reconstructive Surgery

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

1. Covered
 - a. Surgery to correct significant defects from congenital causes, accidents or disfigurement from a disease state.
 - b. Reconstructive breast surgery as a result of a mastectomy (other than lumpectomy). Surgery on the non-diseased breast needed to establish symmetry between the two breasts is Covered.
2. Limitations/Exclusions
 - a. Benefits for services, supplies or prosthetics primarily to improve appearance are not Covered.
 - b. Surgeries in order to correct or repair the results of a prior surgical procedure of which the primary purpose was to improve appearance are not Covered.
 - c. Surgeries and related services to change sex are not Covered.

L. Therapeutic/Rehabilitative Services

Medically Necessary and Appropriate therapeutic services intended to restore bodily function.

1. Covered
 - a. Inpatient, outpatient, home health or office therapeutic services which are expected to result in significant improvement in the Member's condition

resulting from an Acute disease state or injury.

- b. Therapies include physical therapy, speech therapy, occupational therapy, manipulative therapy, cardiac and pulmonary rehabilitative services.

2. Limitations/Exclusions

- a. Treatment beyond what can reasonably be expected to significantly improve health, including therapeutic treatments for ongoing maintenance is not Covered.
- b. Complementary and alternative therapeutic services for whose value have not yet been determined to be Medically Necessary are not Covered.
- c. Coverage is limited to a total of 60 treatment visits for each rehabilitative service (See Attachment C "Schedule of Benefits") per Calendar Year performed in the office, outpatient facility or Home Health setting. This limit does not include services received as the result of an Inpatient Hospital, Skilled Nursing or Rehabilitative Facility stay.

M. Durable Medical Equipment

Medically Necessary and Appropriate medical equipment or items, which in the absence of illness or injury, is of no medical or other value to You. Items that can withstand repeated use in an ambulatory or home setting.

1. Covered

- a. Maximum Allowable rental charge. Not to exceed the total Maximum Allowable Charge for purchase. The Plan may have the option to recommend initial purchase of the equipment.
- b. The repair, adjustment or replacement of components and accessories necessary for the effective functioning of Covered equipment.
- c. Supplies and accessories necessary for the effective functioning of Covered Durable Medical Equipment.
- d. The replacement of items needed as the result of normal development and aging.

2. Limitations/Exclusions

- a. Charges exceeding the total cost of the Maximum Allowable Charge to purchase the equipment are not Covered.

- b. Unnecessary repair, adjustment or replacement or duplicates of any such equipment is not Covered.
- c. Supplies and accessories that are not necessary for the effective functioning of the Covered equipment are not Covered.
- d. Items to replace those that were lost, damaged, stolen or prescribed as a result of new technology are not Covered.

N. Prosthetics/Orthotics

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

1. Covered

- a. The initial purchase of surgically implanted prosthetic or orthotic devices.
- b. The repair, adjustment or replacement of components and accessories necessary for the effective functioning of Covered equipment.
- c. Splints and braces that are custom made or molded, and are incident to a Practitioner's services or on a Practitioner's order.
- d. The replacement of Covered items required as a result of growth, normal wear and tear, defects or aging.
- e. The initial purchase of artificial limbs or eyes.
- f. The first pair of eyeglasses or contact lenses prescribed as a result of a cataract operation.

2. Exclusions

- a. Hearing aids.
- b. Prosthetics primarily for cosmetic purposes, including but not limited to wigs, or other hair prosthesis or transplants.
- c. Items to replace those that were lost, damaged, stolen or prescribed as a result of new technology.
- d. The replacement of contacts after the initial pair has been provided following cataract surgery.

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

O. Organ Transplants

As soon as Your Provider tells You that You might need a transplant, You or Your Provider needs to contact Transplant Case Management.

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

You have access to three levels of benefits: In-Transplant Network, In-Network, and Out-of-Network. If You go to an In-Transplant Network Provider, You will have the highest level of benefits.

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

1. Prior Authorization Procedures

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

Transplant Case Management is a mandatory program for those Members seeking transplant services. Call the 800 number on the front of the membership ID card for customer service, and they can transfer You to Transplant Case Management. We must be notified of the need for a transplant in order for it to be a Covered Service.

2. Covered Services

The following Medically Necessary and Appropriate transplant services and supplies which have received Prior Authorization and are provided in connection with a Covered Procedure:

- a. Medically Necessary and Appropriate services and supplies, otherwise Covered under this EOC.
- b. Medically Necessary and Appropriate services and supplies for each listed organ transplant are Covered only when Transplant Case Management approves a transplant. **Not all In-Network Providers are in Our Transplant Network. Please check with Transplant Case Management to see which Hospitals are in Our Transplant network.**
- c. Medically Necessary and Appropriate services and supplies for each listed organ transplant are Covered only when Transplant Case Management approves a transplant.
- d. Travel expenses for Your evaluation prior to a Covered Procedure, and to and from the site of a Covered Procedure by: (1) private car; (2) ground or air ambulance; or (3) public transportation. This includes Your and a companion's travel expenses. The companion must be Your Spouse, family member or Your guardian.
 - (1) Travel by private car is limited to reimbursement at the IRS mileage rate in effect at the time of travel for travel more than 30 miles away from Your home to and from a facility in the Transplant Network.
 - (2) Meals and lodging expenses are Covered if You or Your companion travels more than 30 miles each way, and are limited to \$150 daily.
 - (3) The aggregate limit for travel expenses is \$10,000 per Covered Procedure and is included in Your Lifetime Benefit Maximum.
 - (4) Travel Expenses are Covered only if You go to a Contracted Transplant Institution;

- e. Donor Organ Procurement. If the donor is not a Member, Covered Services for the donor are limited to those services and supplies directly related to the transplant service itself: (1) testing for the donor's compatibility; (2) removal of the organ from donor's body; (3) preservation of the organ; and (4) transportation of the organ to the site of transplant. Services are Covered only to the extent not covered by other health coverage. The search process and securing the organ are also Covered under this benefit. Complications of donor organ procurement are not Covered. The cost of Donor Organ Procurement is included in the total cost of Your Organ Transplant.

3. Conditions/Limitations

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

- a. You or Your Physician must notify Transplant Case Management prior to Your receiving any transplant service, including pre-transplant evaluation, and obtain Prior Authorization. If Transplant Case Management is not notified, the transplant and related procedures will not be Covered at all;
- b. Transplant Case Management will coordinate all transplant services, including pre-transplant evaluation. You must cooperate with Us in coordination of these services;
- c. Failure to notify Us of proposed transplant services, or to coordinate all transplant related services with Us, will result in the reduction or exclusion of payment for those services;
- d. You must go through Transplant Case Management and receive Prior Authorization for Your transplant to be Covered;
- e. For Covered Transplants, other than kidney transplants, once You have notified Transplant Case Management and received Prior Authorization, You may decide to have the transplant performed outside the Transplant Network. **However, Your benefits will be greatly limited, as described below. Only the Transplant Maximum**

Allowable Charge for the Service provided will be Covered.

- i. In-Transplant Network transplants. You have the transplant performed at an In-Transplant Network Provider. You receive the highest level of reimbursement for Covered Services. The Plan will reimburse the In-Transplant Network Provider at the benefit level listed in Attachment C: Schedule of Benefits, at the Transplant Maximum Allowable Charge. The In-Transplant Network Provider cannot bill You for any amount over the Transplant Maximum Allowable Charge for the transplant, which limits Your liability;
- ii. In-Network Provider transplants. You have the transplant performed outside the Transplant Network, but still at a facility that is a Participating Provider or a BlueCard PPO Participating Provider. The Plan will reimburse the Participating Provider or BlueCard PPO Participating Provider at the Participating Provider benefit levels listed in Attachment C, Schedule of Benefits, limited to the Transplant Maximum Allowable Charge. Participating Providers that are not in Our Transplant Network may charge more than the Transplant Maximum Allowable Charge (TMAC) and may bill You for the amount in excess of the TMAC – this amount may be substantial. There is no maximum to Your liability.
- iii. Out-of-Network Provider transplants. You have the transplant performed by an Out-of-Network Provider (i.e., outside the Transplant Network, and not at a facility that is a Network Provider or a BlueCard PPO Participating Provider). The Plan will reimburse the Out-of-Network Provider only at the Out-of-Network Provider

benefit level listed in Attachment C, Schedule of Benefits, limited to the Transplant Maximum Allowable Charge. There is no maximum to Your liability. **The Out-of-Network Provider also has the right to bill You for any amount not Covered by the Plan - this amount may be substantial.**

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

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

and have Your transplant performed at a Contracted Transplant Institution, the transplant expenses specified in Attachment C, Schedule of Benefits are Covered, up to Your Lifetime Maximum.

4. Exclusions

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

- a. If You do not receive Prior Authorization, the transplant and related services will not be Covered;
- b. Any service specifically excluded under Attachment B, Exclusions from Coverage, except as otherwise provided in this section;
- c. Services or supplies not specified as Covered Services under this section;
- d. If You receive Prior Authorization through Transplant Case Management, but do not obtain services through the Transplant Network (or a Participating Provider in the case of kidney transplants), You will have to pay the Provider any additional charges not Covered by the Plan;
- e. Any attempted Covered Procedure that was not performed, except where such failure is beyond Your control;
- f. Services which are covered under any private or public research fund, regardless of whether You applied for or received amounts from such fund;
- g. Non-Covered Services;
- h. Any non-human, artificial or mechanical organ;
- i. 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;
- j. Donor services including screening and assessment procedures which have not received Prior Authorization from Us;
- k. 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;
- l. Harvest, procurement, and storage of stem cells, whether obtained from

peripheral blood, cord blood, or bone marrow when reinfusion is not scheduled within 3 months of harvest;

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

P. Supplies

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

- 1. Covered
 - a. Supplies for the treatment of disease or injury.
- 2. Limitations/Exclusions
 - a. Items that can be obtained without a prescription are not Covered.
 - b. Items must be prescribed by a Practitioner.

Q. Dental Services and TMJ

Medically Necessary and Appropriate services performed by a Doctor of Dental Surgery (DDS), a Doctor of Medical Dentistry (DMD) or any Practitioner licensed to perform dental related oral surgery except as indicated below.

- 1. Covered
 - a. Removal of impacted teeth, including wisdom teeth.
 - b. Benefits are available for dental services and oral surgery as a result of an injury to the jaw, natural teeth, mouth, or face.
 - c. Benefits are available for inpatient or outpatient expenses, including anesthesia, in connection with a dental procedure that includes:
 - (1) Complex oral surgical procedures which 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 which significantly increases the probability of complications.

- (3) Mental illness or behavioral condition which 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.
- (5) Dental surgery performed on a Member 8 years of age or younger, where such procedure cannot be provided safely in a dental office setting.

2. Limitations/Exclusions

- a. Any dental service not specifically listed as Covered is not Covered.
 - b. Services as a result of an injury to the jaw, natural teeth, mouth, or face must be started within one year from the date of the injury or they will not be Covered.
 - c. The facility charges for surgery will be Covered under the conditions of the inpatient Hospital benefit.
 - d. Treatment for correction of underbite, overbite, and misalignment of the teeth including but not limited to, braces for dental indications, orthognathic surgery, and occlusal splints.
 - e. Professional Charges are not Covered except as indicated above.
3. Benefits are available for the diagnosis and treatment of temporomandibular joint syndrome (TMJ) and associated pain of the joint between the temporal bones and the mandible.
- a. Covered
 - (1) History exam and office visit, x-rays, diagnostic study casts, appliances to stabilize jaw joint and medications.
 - b. Limitations/Exclusions
 - (1) Occlusal splints and braces are not Covered.
 - (2) \$1500 limit per Member per Calendar Year for non-surgical treatment of TMJ.

R. Diagnostic Services

Medically Necessary and Appropriate diagnostic radiology services and laboratory tests.

1. Limitations/Exclusions
 - a. Diagnostic services that are not Medically Necessary and Appropriate are not Covered.

S. Behavioral Health Services

Medically Necessary and Appropriate treatment of mental health and substance abuse disorders (behavioral health conditions) characterized by abnormal functioning of the mind or emotions and in which psychological, emotional or behavioral disturbances are the dominant features. Substance Abuse treatments are limited to 2 treatments per lifetime.

All inpatient levels of care, which include Acute care, residential care, partial hospital care; electro-convulsive therapy (ECT) and intensive outpatient programs must receive Prior Authorization.

Outpatient treatment includes outpatient visits to professionals provided in a Practitioner's office or community mental health center.

1. Covered
 - a. Inpatient and outpatient services for care and treatment of mental health disorders and substance abuse disorders.
 - b. You may substitute other levels of care for inpatient days as follows:
 1. Two residential treatment days for 1 inpatient day.
 2. Two partial hospital days for 1 inpatient day.
 3. Three intensive outpatient program days for 1 inpatient day.
 - c. Other Case Management benefits may be available.
 - d. Outpatient treatment visits for medication management do not count toward the number of mental health outpatient visits per year. Medication management means pharmacological management, including prescription, use, and review of medication with no more than minimal medical psychotherapy.

2. Exclusions
 - a. Non-emergency behavioral health Acute care, residential care, partial hospitalization, intensive outpatient programs stays or treatment in halfway

houses or group homes, and electro-convulsive treatments that are not Prior Authorized during Your treatment in a facility or program, whether the facility or program is a Network Provider or an Out-of-Network Provider. Emergency Care Services require a notification within 24 hours to receive Prior Authorization.

- b. Pastoral counseling.
- c. Marriage and family counseling without a behavioral health diagnosis.
- d. Vocational and educational training and/or services.
- e. Custodial or domiciliary care.
- f. Conditions without recognizable ICD-9 diagnostic classification, such as adult child of alcoholics (ACOA), and co-dependency and self-help programs.
- g. Sleep disorders.
- h. Services related to mental retardation or developmental disabilities.
- i. Habilitative as opposed to rehabilitative services, i.e., services to achieve a level of functioning the individual has never attained.
- j. Behavioral problems such as anti-social personality disorders, sexual deviation or dysfunction or social maladjustment.
- k. Any care in lieu of legal involvement or incarceration.
- l. Pain management.
- m. Hypnosis or regressive hypnotic techniques.
- n. Charges for telephone consultations, missed appointments, completion of forms, or other administrative services.
- o. Methadone and methadone maintenance therapy.
- p. Buprenorphine and buprenorphine maintenance therapy.
- q. **Call the toll-free number indicated on the back of the membership ID card if You have questions about Your Behavioral Health Services benefit.**

T. Vision

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

1. Covered

- a. Services and supplies for the diagnosis and treatment of diseases and injuries to the eye.
- b. First set of eyeglasses or contact lens following cataract surgery or the congenital absence of the crystalline of the eye or the treatment of corneal disease.

2. Limitations/Exclusions

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

- a. Services and supplies to detect or correct refractive errors of the eyes are not Covered.
- b. Eyeglasses, contact lenses and examinations for the fitting of eyeglasses and contact lenses are not Covered, except for the first set of eyeglasses or contact lens following cataract surgery.
- c. Eye exercises and/or therapy are not Covered.
- d. Visual training is not Covered.

EVIDENCE OF COVERAGE
ATTACHMENT B:
EXCLUSIONS FROM COVERAGE

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

1. Services or Supplies not listed as Covered Services under Attachment A, Covered Services.
2. Services or supplies that are determined to be not Medically Necessary and Appropriate or have not been authorized by the Plan.
3. Illness or injury resulting from war and covered by veteran's benefit or other coverage for which the Member is legally entitled and which occurred before the Member's Coverage began under this EOC.
4. Non-medical self-treatment or training.
5. Staff consultations required by Hospital or other facility rules.
6. Services which are free.
7. Any work related illness or injury, unless resulting from self-employment.
8. Personal and convenience items and services such as barber and beauty services, television, air conditioners, humidifiers, air filters, heaters, physical fitness equipment, saunas, whirlpools, water purifiers, swimming pools, tanning beds and other recreational equipment, weight loss programs, physical fitness programs or self-help devices which are not primarily medical in nature, even if ordered by a Practitioner.
9. Services or confinements that occurred before the Member's effective date for Coverage with this Plan or after the date Coverage terminate. Benefits for Hospital Services will be provided where a Member is hospitalized on the date the Coverage is terminated, in which case benefits for Hospital Services will be provided for: (1) 60 days; (2) until the Member is covered under another Plan; (3) until the Member is discharged; or (4) until the Member reaches the Lifetime Maximum, 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 6 months following the child's birth.
10. Services or supplies received in a dental or medical department maintained by a mutual benefit association, labor union or similar group.
11. Telephone consultations, or charges for failure to keep a scheduled appointment.
12. Services for providing requested medical information or completing forms.
13. Court ordered examinations and treatment.
14. Room, board and general nursing care rendered on the date of discharge, unless admission and discharge occur on the same day.
15. Charges in excess of the Maximum Allowable Charge for Covered Services or any charges which exceed the Lifetime Maximum.
16. Any service stated in the Attachment A as a Non-Covered Service or Limitation.
17. Charges for telephone consultations, missed appointments, for completion of forms, or other administrative services.
18. Services or supplies related to obesity, including non-surgical treatment of morbid obesity. Surgical treatment for morbid obesity is Covered subject to BCBST medical guidelines.

ATTACHMENT C: Vanderbilt University Network P SCHEDULE OF BENEFITS

**Group Number: 89508
Effective Date: January 1, 2009**

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

Note: For Eligibility Provisions, Please refer to the Plan Document furnished by Vanderbilt University.

	For Services from Vanderbilt Medical Center & VMG Groups The Member Pays:	For Services from a Network Provider The Member Pays:	For Services from an Out-of-Network Provider The Member Pays:¹
Practitioner Services (physician, specialist or nurse practitioner)			
Office Services – including diagnostic testing performed in the practitioner’s office and injections	\$20 Copayment	\$30 Copayment per visit (only applies to the first visit for maternity services)	40% Coinsurance after Deductible
Services performed outside the practitioner’s office	10% Coinsurance after Deductible	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Preventive Services			
Routine physical exam, routine gynecological exam (including Pap test), mammograms, prostate cancer screening, colonoscopy, pediatric routine physical exams, and pediatric immunizations (to age 6)	\$20 Copayment	\$30 Copayment	No Coverage
Facility Services			
Inpatient Hospital ²	10% Coinsurance after Deductible	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Facility Charges for Outpatient Surgery	10% Coinsurance after Deductible	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Other Outpatient Services	10% Coinsurance after Deductible	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Skilled Nursing/Rehab ² (limited to 60 days combined)	10% Coinsurance after Deductible	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Urgent Care Services	10% Coinsurance after Deductible	20% Coinsurance after Deductible and \$50 Copayment	40% Coinsurance after Deductible and \$50 Copayment
Emergency Care Services	10% Coinsurance after Deductible	20% Coinsurance after Deductible and \$100 Copayment	40% Coinsurance after Deductible and \$100 Copayment

Other Services			
Ambulance	10% Coinsurance after Deductible	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Durable Medical Equipment, Prosthetics & Orthotics, including Insulin Pump	10% Coinsurance after Deductible	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Home Health Services (limited to 120 visits per year) ⁴	10% Coinsurance after Deductible	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Hospice ⁴	10% Coinsurance after Deductible	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Therapeutic Services (limited to 60 visits per therapy per year) ³	10% Coinsurance after Deductible	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Chiropractic Services (limited to \$500 per Member per year)	Not applicable	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Behavioral Health			
Inpatient – 30 days per year ^{4 5}	10% Coinsurance after Deductible	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient – 30 visits per year	\$20 Copayment per visit	\$30 Copayment per visit	40% Coinsurance after Deductible
Annual Deductible			
Individual	\$100	\$300	\$500
Family	\$200	\$600	\$1,000
4 th Quarter Deductible Carryover	Included		
Annual Out-of-Pocket Maximum			
Individual	\$2,500		\$5,000
Family	\$5,000		\$10,000
Lifetime Maximum			
Unlimited			
Organ Transplant Services			
Covered Organ Transplant Services, all transplants except kidney ⁶	In-Transplant Network benefits: 10% after Network Provider Deductible	Network Providers not in Our Transplant Network⁽⁷⁾ 10% of Transplant Maximum Allowable Charge (TMAC) after Network Provider Deductible. Amounts over TMAC do not apply to the Out-of-Pocket Maximum and are not covered.	Out-of-Network Providers - 60% of Transplant Maximum Allowable Charge (TMAC), after Out-of-Network Provider Deductible. Amounts over TMAC do not apply to the Out-of-Pocket Maximum and are not Covered.
Kidney transplants ⁶	Network Providers – 10% after Network Provider Deductible		Out-of-Network Providers: 60% of Maximum Allowable Charge (MAC), after Out-of-Network Provider Deductible. Amounts over MAC do not apply to the Out-of-Pocket Maximum and are not Covered.

1. *Benefit payment for services from an Out-of-Network Provider is based on BlueCross BlueShield of Tennessee's Maximum Allowable Charge. You are responsible for paying any amount exceeding the Maximum Allowable Charge, in addition to Deductibles, and Coinsurance payments based on the Maximum Allowable Charge. Amount in excess of the Maximum Allowable Charge do not apply to the Out-of-Pocket limits.*
2. *Services require Prior Authorization. Out-of-Network benefits are reduced to 50% when Prior Authorization is not obtained by the Member.*
3. *Includes physical, speech, manipulative, and occupational therapy and cardiac and pulmonary rehabilitation.*
4. *Requires Prior Authorization. Benefits for Covered Services received from an Out-of-Network Provider are reduced to 50% when Prior Authorization is not obtained by the Member.*
5. *Substance Abuse treatment is limited to 2 episodes (inpatient) per lifetime.*
6. *All Organ Transplants require Prior Authorization. Benefits will be denied without Prior Authorization. For other than kidney transplants, Transplant Network Providers are different from Network Providers for other services. Call customer service before any pre-transplant evaluation or other transplant service is performed to request approval, and to obtain information about Transplant Network Providers. Network Providers that are not in the Transplant Network may balance bill the Member for amounts over the Transplant Maximum Allowable Charge. These amounts are not Covered by the Plan.*
7. *Network Providers not in our Transplant Network include Network Providers in Tennessee and BlueCard PPO Providers outside Tennessee.*

Services Requiring Prior Authorization

The following services must be approved by BlueCross BlueShield of Tennessee, **in advance**, in order for Benefits to be paid without Penalty. If Prior Authorization is not obtained by the Member, Benefits for any of the following services received from Out-of-Network Providers will be reduced to 50%:

- Inpatient Hospital stays.
- Skilled Nursing and Rehabilitation services.
- Home Health services.
- Inpatient Behavioral Health services.

Additionally, all Organ Transplants require approval by BlueCross BlueShield of Tennessee, **in advance**, in order to be Covered. Benefits will be *denied* for organ transplants without Prior Authorization.

EVIDENCE OF COVERAGE

ATTACHMENT D: STATEMENT OF ERISA RIGHTS

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

1. Examine, without charge, at the office of the Plan Administrator (Plan Sponsor, usually the Employer) and at other specified locations, such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration;
2. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator (Plan Sponsor, i.e., the Employer). The Plan Administrator may make a reasonable charge for these copies; and
3. Receive a summary of the plan's annual financial report. The Plan Administrator (Plan Sponsor, usually the Employer) is required by law to furnish each participant with a copy of this summary annual report.
4. Continue Your health care Coverage if there is a loss of coverage under the Plan as a result of a qualifying event. You may have to pay for such Coverage. Review the Continuation of Coverage section of this EOC for the rules governing your COBRA Continuation Coverage rights.

If You have Creditable Coverage from a prior employer's plan, that Creditable Coverage may reduce or eliminate any Pre-existing Condition Waiting Period under this Plan. You should be given a Certificate of Creditable Coverage, free of charge, when:

- a. You lose Coverage under the Plan;

- b. You become entitled to elect COBRA Continuation Coverage;
- c. Your COBRA Continuation Coverage ceases if You request the Certificate of Creditable Coverage before losing Coverage, or within 24 months after losing Coverage.

Without evidence of Creditable Coverage, You may be subject to a Pre-existing Condition exclusion for 12 months (18 months for late enrollees) after You enroll for Coverage under this Plan.

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

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

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

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

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

MATERNITY AND NEWBORN COVERAGE

Your Plan provides maternity and newborn infant coverage. Federal law generally prohibits this Plan from restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours where applicable.) In any case, the Plan may not, under Federal law, require that a Provider obtain authorization to prescribe a length of stay not in excess of the above periods. Please refer to the Covered Services section of this EOC for details.

IMPORTANT NOTICE FOR MASTECTOMY PATIENTS

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

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

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

NOTICE REGARDING CERTIFICATES OF CREDITABLE COVERAGE

If You lose eligibility for Coverage under this Plan, We will send You a Certificate of Creditable Coverage, at Your last address, on file with Us.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

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



**BlueCross BlueShield
of Tennessee***

801 Pine Street
Chattanooga, Tennessee 37402-2555

www.bcbst.com

BENEFIT QUESTIONS?
Call the Customer Service
Number on the membership I.D. Card

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SELF-FUNDED EOC (1/01)

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