www.trh.com

TRH Rx
July 2015

Please read this Contract carefully and keep it in a safe place for future reference. It explains Your Coverage. If You have questions about Your Coverage, please write or call:

TRH Health Plans
P.O. Box 313
Columbia, TN 38402-0313
(877) 874-8323

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Your Coverage

INTRODUCTION

Please read this Contract carefully. It describes Your rights and duties as a Subscriber/Member. It is important to read the entire Contract. Certain services are Non-Covered Services. Other Covered Services are limited. We will not pay for any service not specifically listed as a Covered Service, even if a health care practitioner recommends that Non-Covered Service.

The word "Coverage" means the benefits available to You under this Contract. "You" and "Your" mean the Subscriber.

This Contract replaces any Certificate, Evidence of Coverage ("EOC"), or Contract previously issued by Tennessee Rural Health Improvement Association ("TRH Health Plans") in effect prior to the Effective Date of this Contract.

This Coverage may be renewed by payment of the Premium.

Any Grievance related to this Coverage will be resolved in accordance with the Grievance Procedure section of this Contract.

Words defined in the Glossary of this Contract are capitalized throughout.

If You are a new Subscriber, and You are not satisfied with this Coverage, You may return this Contract to TRH Health Plans within 30 days of receipt. In this event, Your Coverage will terminate and any Premium paid for this Coverage will be refunded minus any benefits paid.

If You have questions, please contact one of the customer service representatives at the number on the back of Your Plan ID Card or Your TRH Health Plans representative at Your local Farm Bureau office.

RIGHT TO RECEIVE AND RELEASE INFORMATION

You authorize TRH Health Plans, its affiliate, or a third party vendor to use and release personal information for Yourself. This authorization includes any and all medical and dental records obtained, used or released in connection with administration of this Coverage. Personal information will be maintained and released in accordance with applicable state and federal laws and the TRH Health Plans Notice of Privacy Practices. In the event that information in this Contract is inconsistent with the TRH Health Plans Notice of Privacy Practices, the terms of the TRH Health Plans Notice of Privacy Practices will prevail and this Contract will be deemed to be modified to the extent necessary for consistency. Your authorization is deemed given by Your signature on Your Application and Your acceptance of Coverage. Additional authorization and/or consent may be required at the time Covered Services are obtained. This authorization remains in effect throughout the period You are covered under this Contract and survives the termination of this Coverage to the extent that such information or records relate to services rendered while You were covered under this Contract. Please consult the TRH Health Plans Notice of Privacy Practices for more information about Your rights regarding the use and release of Your personal information. You can find a copy of the TRH Health Plans Notice of Privacy Practices at www.trh.com or You can contact the TRH Health Plans representative at Your local Farm Bureau office.

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

Ryan Brown

Corporate Secretary

Section I
Network Pharmacies

HOW A PPO PLAN WORKS

You have a PPO plan. TRH Health Plans, its affiliate, or a third party vendor contracts with a network of Pharmacies. These Pharmacies, called Network Pharmacies, agree to special pricing arrangements and have agreed to accept the negotiated fees as payment in full, including any portion of the fees that You must pay due to the Deductible, Coinsurance or other out-of-pocket expenses. The allowable Charges used in the calculation of the payable benefit to participating Pharmacies will be determined by the negotiated rates in the network contract.

Your PPO plan has two levels of benefits. By using Network Pharmacies You receive the highest level of benefits. However, You can choose to use Pharmacies that are not Network Pharmacies. These Pharmacies are called Out-of-Network Pharmacies. When You use Out-of-Network Pharmacies Your benefits will be reduced. You will be responsible for amounts that an Out-of-Network Pharmacy bills above the Maximum Allowable Charge and any amounts not covered under the terms of this Contract.

The reference to Pharmacies as "Network Pharmacies" or "Out-of-Network Pharmacies" is not a statement about their abilities.

To find out which network a Pharmacy belongs to, please refer to the Pharmacy Directory, or call the toll-free number that is listed on the back of Your identification card. The participation status of Pharmacies may change from time to time.

- If a Pharmacy belongs to the **OptumRx** network, claims for Covered Charges will be processed in accordance with the network benefit levels listed in the Schedule of Benefits.
- This plan uses the **OptumRx Specialty Pharmacy** for self-administered pharmacy products. When using **OptumRx Specialty Pharmacy**, claims for Covered Charges will be processed in accordance with the network benefit levels listed in the Schedule of Benefits.
- For services received from a Pharmacy that does not participate in the networks shown above, claims for Covered Services will normally be processed in accordance with the Out-of-Network benefit levels listed in the Schedule of Benefits. These Pharmacies may charge their normal rates for prescription drugs, so You may pay more. You are responsible for paying the balance of these claims after the Plan pays its portion, if any.

RELATIONSHIP WITH NETWORK PHARMACIES

Independent Contractors

Network Pharmacies are not employees, agents or representatives of TRH Health Plans. Network Pharmacies contract with TRH Health Plans, its affiliate, or a third party vendor which has agreed to pay them for rendering Covered Services to Members. Network Pharmacies, in consultation with their patients, are responsible for making all medical treatment decisions. TRH Health Plans does not make medical treatment decisions under any circumstances.

Network Pharmacies can dispute Coverage decisions with which they disagree. If the Network Pharmacy does not dispute a Coverage decision, You may request reconsideration of that decision as explained in the Grievance Procedure section of this Contract.

Termination of Pharmacies' Participation

TRH Health Plans or any Network Pharmacy may end their relationship with each other at any time. A Network Pharmacy may limit the number of Members that he, she or it will accept as patients. TRH Health Plans does not guarantee that any specific Network Pharmacy will be available to render services while the Member is covered.

MEMBER/PHARMACY RELATIONSHIP

The choice of a Pharmacy is solely the decision of the Member.

TRH Health Plans does not furnish Covered Services. TRH Health Plans is not liable for any act or omission of any Pharmacy, bears no responsibility for a Pharmacy's failure or refusal to provide Covered Services to a Member and cannot be held responsible for any injuries or damage caused by negligence or malpractice of a Pharmacy.

Section II
Glossary

Billed Charges - The amount that a Pharmacy Charges for services rendered. Billed Charges may be different from the Maximum Allowable Charge for a Covered Service.

Calendar Year – The period of time beginning at 12:01 a.m. on January 1st and ending at 12:00 a.m. on the following January 1st.

Charge, Charge for Coverage or Charges - The amount paid by the Member each billing cycle for Coverage provided under the terms of this Contract.

Coinsurance - The share of the cost of Covered Services by TRH Health Plans and You, after Your Deductible has been satisfied. Your Coinsurance is calculated at 100% minus Our Coinsurance. In addition to Your Coinsurance, You are responsible for the difference between Billed Charges and the Maximum Allowable Charge for Covered Services if the Billed Charges of a Non-Contracted Pharmacy or an Out-of-Network Pharmacy exceed the Maximum Allowable Charge for such services.

Coinsurance Percentage - The percentage of the Maximum Allowable Charge that will be paid by TRH Health Plans for a Covered Service during a Calendar Year after, and in some cases before, a Member satisfies his or her Deductible.

Compound Drug - An outpatient prescription drug, which is not commercially prepared by a licensed pharmaceutical manufacturer in a dosage form approved by the Food and Drug Administration and that contains at least one ingredient classified as a Legend Drug.

Contract - The document describing the terms and conditions of Your Coverage.

Coverage - The benefits available to a Member under this Contract.

Covered Charge - The amount of Billed Charges eligible for payment.

Covered Service - Medically Necessary and Medically Appropriate services, drugs or supplies subject to all terms, conditions, exclusions and limitations set forth in this Contract.

Deductible - The dollar amount You must incur and pay for Covered Services during a Calendar Year before We provide benefits. Any Copayment or balance of Charges (the difference between Billed Charges and the Maximum Allowable Charge) will not be considered when determining whether Your Deductible has been met.

Effective Date - The date a Member's Coverage under this Contract begins.

Explanation of Benefits (EOB) - The form provided to the Subscriber after a claim has been filed notifying the Subscriber which services were covered and which, if any, were not.

Individual Coverage - Coverage for the Subscriber only.

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

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

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

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

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

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

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

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

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

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

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

The medical director shall have discretionary authority to make a determination concerning whether a service, drug or supply is an Investigational Service. If the medical director does not authorize the provision of a service, drug 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**:**

- Your medical records, or
- the protocol(s) under which proposed service, drug or supply is to be delivered, or
- any consent document that You have executed or will be asked to execute, in order to receive the proposed service, drug or supply, or
- the published authoritative medical or scientific literature regarding the proposed service, drug or supply in connection with the treatment of injuries or illnesses such as those experienced by You, or
- regulations or other official publications issued by the U.S. Food and Drug Administration and Health and Human Services, or
- the opinions of any entities that contract with the Plan to assess and coordinate the treatment of Members requiring non-experimental or Investigational Services, or
- the findings of Our contracted Technology Evaluation Center or other similar qualified evaluation entities

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

Maximum Allowable Charge (MAC) - The amount TRH Health Plans has determined to be the maximum amount payable for a Covered Service. Maximum Allowable Charge will be based upon TRH Health Plans, or its affiliate or third party vendor's, contract with a Network

Pharmacy or the amount payable based on TRH Health Plans, or its affiliate or third party vendor's, fee schedule for the Covered Services when rendered by Out-of-Network Pharmacies.

Maximum Annual Benefit - The total dollar amount of benefits available under this Plan during a Calendar Year, as stated in the Schedule of Benefits.

Medically Appropriate – Services which have been determined by the medical director, in his or her discretion, to be of value in the care of a specific Member. To be Medically Appropriate a service must:

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

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

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

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

Member - Any person enrolled under this Coverage as a Subscriber.

Network Pharmacy - A Pharmacy that has contracted with TRH Health Plans, its affiliate, or a third party vendor to legally dispense prescription drugs to Members, either in person or through home delivery at specified rates. This does not include the Specialty Pharmacy Network.

Non-Covered Charge – The portion of total Charge that is not eligible for consideration of payment.

Non-Covered Service - A service, drug or supply for which no benefits are available.

Out-of-Network Pharmacy – A Pharmacy that has not contracted with TRH Health Plans, its affiliate, or a third party vendor to legally dispense prescription drugs to Members, either in person or through home delivery at specified rates.

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

Pharmacy Director - A pharmacist designated by the Administrator, or that pharmacist's designee, who is responsible for the administration of the Pharmacy programs.

Prior Authorization - A review conducted, prior to delivery of certain services, to determine if such services will be considered Covered Services. The purpose of Prior Authorization is solely to ensure that patients receive services at the appropriate time and in the appropriate setting. Prior Authorization is not a guarantee of benefits. Benefits are based on all terms and conditions of the Coverage in force for the Member at the time Covered Services are provided.

Specialty Pharmacy Products - Injectable, infusion, and select oral medications that require complex care including special handling, patient education and continuous monitoring. Specialty Pharmacy Products are categorized as Provider-administered or self-administered.

Specialty Pharmacy Network Pharmacy - A Pharmacy that has contracted with TRH Health Plans, its affiliate, or a third party vendor to provide Specialty Pharmacy Products to Members at specified rates.

Subscriber, You, Your – The individual who has met all applicable eligibility requirements, has applied for Coverage, and to whom We have issued the Contract.

Waiting Period – The period of time, after the Effective Date, before benefits are payable under this Contract.

Section III
Eligibility

This Contract describes the benefits available to You under the terms of this Pharmacy program. You are called the Subscriber or Member.

TYPES OF COVERAGE AVAILABLE

Individual – Subscriber only

Family benefits are not available under this Plan.

COVERAGE FOR YOU

You are eligible for this Coverage if You:

1. are a member of Your local Tennessee Farm Bureau/TRH; and
2. meet TRH medical underwriting requirements; and
3. meet any additional requirements established.

TRH reserves the right to change these eligibility requirements at any time.

Section IV
General Provisions

APPLICABLE LAW

The laws of the state of Tennessee govern this Coverage.

BENEFITS TO WHICH A MEMBER IS ENTITLED

Benefits are provided only for Covered Services received on or after the Member's Effective Date and prior to the termination date of the Member's Coverage.

THE PLAN IDENTIFICATION (ID) CARD

1. Your Plan ID Card is proof of Your right to receive the benefits of this Plan.
2. You should carry Your Plan ID Card at all times.
3. Only You may use Your Plan ID Card.
4. Be sure to show Your Plan ID Card each time You visit the Pharmacy. Inform Your pharmacist that Prior Authorization may be required. The Plan ID Card contains special instructions on how to initiate the Prior Authorization process.

THE CONTRACT

This Contract explains the benefits available to Members. This Coverage cannot be transferred or assigned to another party. We may change the terms of Your Coverage by giving You at least 30 days notice before the Effective Date of any change. Your continued payment of Premium indicates acceptance of the change. Notice of any change to the terms of Your Coverage will be mailed to You at the address shown in Our records.

LEGAL ACTION

You cannot bring legal action under this Plan until 60 days after proof of loss has been furnished. You cannot bring legal action after 3 years after the time proof of loss is required.

RIGHT TO REQUEST INFORMATION

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

ADMINISTRATIVE ERRORS

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

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

TIME LIMIT ON CERTAIN DEFENSES

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

SUBROGATION AND RIGHT OF RECOVERY

You agree that the Plan shall be subrogated to and/or have the right to recover amounts paid to provide Covered Services to You for illnesses or injuries caused by third parties, including the right to recover the reasonable value of prepaid services rendered by Network Pharmacies.

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

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

To enable the Plan to protect its rights under this section, You are required to notify the Plan promptly if an illness or injury is caused by a third party. You are also required to cooperate with the Plan and to execute any documents that the Plan deems necessary to protect its rights under this section. If You settle any claim or action against any third party without the Plan's consent, You shall be deemed to have been made whole by the settlement, and the Plan shall be entitled to immediately collect the present value of its rights as a first priority claim from the settlement fund. Any such proceeds of settlement or judgment shall be held in trust by You for the Plan's benefit. The Plan shall also be entitled to recover reasonable attorneys' fees incurred in collecting proceeds held by You in such circumstances.

NOTICES

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

TRH Health Plans
P.O. Box 313
Columbia, Tennessee 38402-0313.

We will mail notices to You at the most recent address on file. It is Your responsibility to maintain Your current address on file with Us.

Section V
Premium & Termination of Coverage

PREMIUM

We may change Your Premium by giving You at least 30 days notice before the Effective Date of any Premium change. Your continued payment of Premium indicates acceptance of the change.

Your Coverage is age rated based on Your age as of January 1 of the Calendar Year. Your Premium will automatically change on the first billing date of the following Calendar Year after You move to a different age bracket.

Your Coverage is also subject to separate and additional general rate increases.

YOUR PREMIUM

Your Premium must be submitted to TRH Health Plans. Your first Premium will be billed by paper invoice. Payment of Your first Premium indicates acceptance of Your Coverage offer. All subsequent Premium payments will occur by bank draft.

Should Your bank draft be dishonored by Your bank, You could forfeit Your Coverage. Your Coverage is subject to a 10 day grace period. If Your Premium is not paid within Your grace period, Your Coverage will terminate retroactively effective as of the Premium due date.

FEE FOR DEFAULT OF PAYMENT

Should Your bank draft be dishonored by Your bank, You will be responsible for default fees in the amount of $25.

RESTORATION OF COVERAGE

If Your Coverage has been cancelled due to non-payment of Premium within Your grace period Your Coverage may be restored by paying the total Premium due, including any applicable default fees and a restoration fee of $100, to Us within 10 days of the final day of Your grace period.

REFUNDS

In the event a refund of Premium is due, We will make the refund payable to the payor.

CHANGES TO COVERAGE

You can request a change to Your Coverage. Your request is subject to approval by Us and must be made in writing and received by Us at least 10 days prior to the next Premium due date.

TERMINATION OF COVERAGE

Your Coverage may be terminated if:

1. The required Premium for Your Coverage is not received when it is due; or
2. You fail to pay Your Tennessee Farm Bureau Federation or Tennessee Rural Health Improvement Association membership dues; or
3. You fail to cooperate with Us as required by this Contract; or
4. You act in such a disruptive manner as to prevent or adversely affect Our ability to administer Your Coverage; or
5. You request that Your Coverage be cancelled at least 10 days prior to the next Premium due date; or
6. You have resided outside of the United States for 24 consecutive months; or
7. This Plan is terminated; or

8. You have made an intentional material misrepresentation of a material fact or committed fraud against Us. This provision includes, but is not limited to, furnishing incorrect or misleading information, failing to provide accurate information or permitting the improper use of Your Plan ID Card. If You make an intentional misrepresentation of a material fact or commit fraud against Us, We may rescind Your Coverage. This means We will return Premium paid minus any claims paid. If the claims paid exceed Premium paid, We have the right to collect that amount from You. We will notify You 30 days in advance of any rescission.

TRH Health Plans may cancel this Coverage for any of the reasons described herein by providing written notice to You 30 days prior to the date of termination. Notice will be mailed to You at the most recent address on file. It is Your responsibility to maintain Your current address on file with Us.

If Coverage terminates as a result of Your death, Your Coverage will be terminated on the date of Your death and Your estate is entitled to a refund of any unused Premium.

PAYMENT FOR SERVICES RENDERED AFTER TERMINATION OF COVERAGE
If You receive and We pay for Covered Services after the termination of Coverage, We may recover the amount We pay for such Covered Services from You, plus any costs of recovering such charges, including Our attorney's fees.

We may impose a finance charge of 1 ½ % per month to any amount not remitted to Us within 30 days of the due date.

Section VI
Schedule of Benefits

BENEFITS

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

Calculation of Coinsurance

Your Coinsurance will be based upon the same dollar amount of payment used to calculate the Plan's portion of the claims payment, regardless of whether the Plan payment is based upon a discount or an alternative method of payment.

This section shows how much the Plan pays for Covered Services described in the Member Benefits section.

NOTE: Charges billed by an Out-of-Network Pharmacy or Non-Contracted Pharmacy which exceed the Maximum Allowable Charge will be the responsibility of the Member.

There is a Waiting Period of 60 days after the Effective Date before benefits are payable.

Calendar Year Deductible	Network Benefit	Out-of-Network Benefit
Deductible Maximum per Member	**$250**	

The Maximum Annual Benefit payable under this Coverage is $6,000.

BENEFITS FOR PRESCRIPTION DRUGS

PRESCRIPTION DRUGS	
Network Pharmacy	**Out-of-Network Pharmacy**
80% of the Maximum Allowable Charge after Deductible	**60% of the Maximum Allowable Charge after Deductible**

BENEFITS FOR SELF-ADMINISTERED SPECIALTY PHARMACY PRODUCTS

SELF-ADMINISTERED SPECIALTY PHARMACY PRODUCTS		
Specialty Pharmacy Network	**Network Pharmacy**	**Out-of-Network Pharmacy**
80% of the Maximum Allowable Charge after Deductible	**80% of the Maximum Allowable Charge after Deductible**	**60% of the Maximum Allowable Charge after Deductible**
Specialty Pharmacy Products are limited to a quantity of up to a 30-day supply per prescription fill.		

PRESCRIPTION DRUGS

Benefits are available for prescription drugs, subject to Deductible and Coinsurance, for use by a Member outside of a hospital or other facility. To be a Covered Service, a prescription drug must be:

1. prescribed on or after the Member's Effective Date by a licensed Practitioner who is authorized by law to prescribe the drug.
2. approved by the Food and Drug Administration (FDA) for the prescribed indication. Benefits will be available for a prescription drug which is prescribed to treat a recognized indication which has not been approved by the FDA for such indication, provided such prescription drug is: (a) otherwise approved by the FDA; and, (b) approved by the medical director based on peer-reviewed medical literature or standard reference compendia.
3. dispensed by a pharmacist, either in person or through home delivery, and
4. unavailable for purchase without a prescription.

Some prescription drugs, including but not limited to prescription drugs purchased outside the United States, may require Prior Authorization or may be subject to quantity limitations. Please call the number listed on Your Plan ID Card for details.

Over-the-counter drugs (not requiring a prescription), prescription devices, vitamins which, by Tennessee law do not require a prescription; and/or prescription drugs dispensed in a physician's office are not Covered Services except as specified in this Contract. Benefits are available for:

1. drugs or formula required to treat Phenylketornuria, and
2. injectable insulin, oral hypoglycemic agents, and syringes.

NETWORK PHARMACY

Network Pharmacies can offer savings through negotiated preferential pricing. To qualify for savings, the Member must utilize a Network Pharmacy. The Member should verify that the Pharmacy is an active Network Pharmacy for the Plan each time he or she visits the Pharmacy to obtain a prescription.

OUT-OF-NETWORK PHARMACY

When You use an Out-of-Network Pharmacy, You will not receive negotiated preferential pricing. You will be reimbursed at the Out-of-Network Coinsurance Percentage applied to the Maximum Allowable Charge after Your Deductible is met.

Charges billed by an Out-of-Network Pharmacy which exceed the Maximum Allowable Charge are the responsibility of the Member.

SELF-ADMINISTERED SPECIALTY PHARMACY PRODUCTS

Benefits are available for certain Medically Necessary and Medically Appropriate self-administered Specialty Pharmacy Products. There is a separate network for Specialty Pharmacy Products which can offer savings through negotiated preferential pricing. Prior Authorization may be required for certain self-administered Specialty Pharmacy Products.

When purchasing a self-administered Specialty Pharmacy Product from a Specialty Pharmacy Network Pharmacy, You will be reimbursed based on the Maximum Allowable Charge at the Specialty Pharmacy Network Coinsurance Percentage after Your Deductible is met.

When purchasing a self-administered Specialty Pharmacy Product from an Out-of-Network Pharmacy, You will be reimbursed, based on the Maximum Allowable Charge, at the Out-of-Network Coinsurance Percentage after Your Deductible is met. Charges billed by an Out-of-Network Pharmacy which exceed the Maximum Allowable Charge are the responsibility of the Member

COMPOUND DRUGS

A Compound Drug is an outpatient prescription drug which is not commercially prepared by a licensed pharmaceutical manufacturer in a dosage form approved by the Food and Drug Administration (FDA) and which contains at least one ingredient classified as a Legend Drug. Compound Drugs, which require a physician's prescription, are prepared by a pharmacist who mixes and adjusts drug ingredients to customize a medication to meet a patient's individual needs.

All ingredients within the Compound Drug must be submitted on the claim. Only prescription drug ingredients covered under the Plan will be included in the payment for the Compound Drug. Non-prescription or over-the-counter drugs will not be paid. Compound Drugs are processed at brand or preferred brand copay.

Prior authorization is required for Compound Drugs over $400.

Check to see if Your Pharmacy is a Network Pharmacy each time You fill a Compound Drug.

When purchasing a Compound Drug from a Network Pharmacy, You will be reimbursed based on the Maximum Allowable Charge at the Network Coinsurance Percentage after Your Deductible is met.

When purchasing a Compound Drug from an Out-of-Network Pharmacy, You will be reimbursed, based on the Maximum Allowable Charge, at the Out-of-Network Coinsurance Percentage after Your Deductible is met. Charges billed by an Out-of-Network Pharmacy which exceed the Maximum Allowable Charge are the responsibility of the Member.

Section VIII
Claims: How And When To File

CLAIMS FOR PRESCRIPTION DRUGS

Your prescription drug claims are electronically submitted by the Pharmacy for reimbursement at the time of service. You are responsible for the full cost of Your prescription drug claims at the time of service and will be reimbursed based on the Maximum Allowable Charge at the applicable Coinsurance Percentage after Your Deductible is met.

Any prescription drug claims not electronically submitted by the Pharmacy must be submitted within 12 months of the date on which the prescriptions were purchased. To obtain a prescription drug claim form, call the toll free number on Your Plan ID Card.

GRIEVANCE PROCEDURE

Our Grievance procedure (the "Procedure") is intended to provide a fair, quick and inexpensive method of resolving any and all disputes with Us. Such disputes include: any matters that cause You to be dissatisfied with any aspect of Your relationship with Us; any Adverse Benefit Determination concerning a Claim; or any other claim, controversy, or potential cause of action You may have against Us. Please contact Your local TRH Health Plans Representative or call the number on the back of Your Plan ID Card: (1) to file a Claim; (2) if You have any questions about this Plan or other documents that You receive from Us (e.g. an Explanation of Benefits); or (3) to initiate a Grievance concerning a dispute.

Adverse Benefit Determination means:

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

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

   A. If a Pharmacy 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 Us to obtain a determination concerning whether the Contract will cover that service. Pharmacies may be required to hold You harmless for the cost of services in some circumstances.

   B. Pharmacies may also appeal an Adverse Benefit Determination through Our Pharmacy dispute resolution procedure.

C. Our determination will not be an Adverse Benefit Determination if: (1) a Pharmacy is required to hold You harmless for the cost of services rendered; or (2) until We have rendered a final Adverse Benefit Determination in a matter being appealed through the Pharmacy dispute resolution procedure.

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

5. The Plan and You may agree to skip one or more of the steps of this Procedure if it will not help to resolve Our dispute.

6. Any dispute will be resolved in accordance with applicable Tennessee or Federal laws and regulations, and this Contract.

Description of the Review Procedures

1. Reconsideration

   A Reconsideration is an informal process that may answer questions or resolve a potential dispute. You should contact Your local TRH Health Plans Representative if You have any questions about how to file a claim or to attempt to resolve any dispute. Requesting a Reconsideration does not stop the time period for filing a Claim or beginning a dispute. You do not have to request a Reconsideration before filing a Grievance.

2. Grievance

   You must submit a written request asking Us to reconsider an Adverse Benefit Determination, or take a requested action to resolve another type of dispute (Your "Grievance"). You must begin the dispute process within 180 days from the date We issue notice of an Adverse Benefit Determination or from the date of the event that is otherwise causing You to be dissatisfied with Us. If You do not initiate a Grievance within 180 days of when We issue an Adverse Benefit Determination, You may give up the right to take any action related to that dispute. The Grievance process that was in effect on the date(s) of service for which You received an Adverse Benefit Determination will apply.

   Contact Your local TRH Health Plans Representative or call the number on the back of Your Plan ID Card for assistance in preparing and submitting Your Grievance. They can provide You with the appropriate form to use in submitting a Grievance. This is the first level Grievance procedure and is mandatory.

3. Grievance Hearing

   After We have received and reviewed Your Grievance, Our first level Grievance committee will meet to consider Your Grievance and any additional information that You or others submit concerning that Grievance. In Grievances concerning urgent care or pre-service claims, We will appoint one or more qualified reviewer(s) to consider such Grievances. Individuals involved in making prior determinations concerning Your dispute are not eligible to be voting members of the first level Grievance committee or reviewers. The first level Grievance committee or reviewers have full discretionary authority to make eligibility, benefit and/or claim determinations, pursuant to the Contract.

4. Written Decision

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

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

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

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

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

a. A statement of the first level Grievance committee's understanding of Your Grievance;

b. The basis of the first level Grievance committee's decision; and

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

5. Second Level Grievance Procedure

You may file a written request for a second level Grievance within 90 days after We issue the first level Grievance committee's decision. Information on how to submit a second level Grievance will be provided to You in the decision letter following the first level Grievance review. Your request along with all submitted information will be forwarded to TRH Health Plans for review.

Your decision concerning whether to file a second level Grievance has no effect on Your rights to any other benefits under the Contract. Any person involved in making a decision concerning Your dispute (e.g. first level Grievance committee members) will not be a voting member of the second level Grievance committee.

6. Second Level Grievance Hearing

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

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

1. Any new, relevant information that You submit for consideration; and
2. Information presented during the hearing. Second level Grievance committee members may ask You questions during the hearing. You may make a closing statement to the committee at the end of the hearing.
3. If You wish to bring a personal representative with You to the hearing. You must notify Us at least 5 days in advance and provide the name, address and telephone number of Your personal representative.

7. Second Level Written Decision

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

1. **A statement of the second level Grievance committee's understanding of Your second level Grievance;**
2. **The basis of the second level Grievance committee's decision; and**
3. **Reference to the documentation or information upon which the second level Grievance committee based its decision. Upon written request, the Plan will send You a copy of any such documentation or information, without charge.**

Independent Review of Medical Necessity Determinations or Coverage Rescissions

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

Your decision concerning whether to request independent review has no effect on Your rights to any other benefits under the Plan. We will pay the fee charged by the independent review organization and its reviewers if You request that We submit a Dispute to independent review. You will be responsible for any other costs that You incur to participate in the independent review process, including attorney's fees.

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

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

The reviewer's decision must state the reasons for the determination based upon: (1) the terms of this Contract; (2) Your medical condition; and (3) information submitted to the reviewer. The reviewer's decision may not expand the terms of the Contract. If You chose to pursue Independent Review following the first level Grievance process, Your Grievance rights would be exhausted following the Independent Review.

COORDINATION OF BENEFITS

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

Periodically We will send You a form to update Your COB information. Please complete the form and return it to Us to ensure Your records are accurate. Failure to return Your COB information to Us shall entitle Us to withhold any and all benefits due the Member until all requested information is received.

Definitions

The following terms apply to this provision:

a. "**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;
- group practice, individual practice, or other pre-paid insurance;
- coverage under labor management trust Plans or Employee benefit organization Plans;
- coverage under government programs to which an Employer contributes or makes payroll deductions;
- coverage under a governmental Plan or coverage required or provided by law. This does not include a state Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time); and
- any other arrangement of health coverage for individuals in a group.

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

b. "**This Plan**" refers to the part of the Contract under which benefits for health care expenses are provided.

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

c. 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 two Plans covering the person, This Plan may be a Primary Plan as to one or more Other Plans, and may be a Secondary Plan as to a different Plan or Plans.

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

The reasonable cash value of a service is deemed to be both an Allowable Expense and a benefit paid when a Plan provides benefits in the form of services.
The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition, unless the patient's stay in a private hospital room is Medically Necessary and Medically Appropriate, either in terms of generally accepted medical practice, or as specifically defined in the Plan.
We will determine only the benefits available under This Plan. You are responsible for supplying them with information about Other Plans so they can act on this provision.

e. "**Claim Determination Period**" means a Calendar Year. It does not, however, include any part of a year during which a person has no Coverage under This Plan or any part of a year prior to the date this COB provision or a similar provision takes effect.

Effect on Benefits

This provision applies where there is a basis for a claim under This Plan and the Other Plan and when benefits of This Plan are determined after the Other Plan(s).

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

- the benefits that would be payable for the Allowable Expenses under This Plan, in the absence of this COB provision; and
- the benefits that would be payable for the Allowable Expenses under the Other Plan(s), in the absence of provisions with a purpose similar to that of this COB provision, whether or not a claim for benefits is made; exceed Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the Other Plan(s) do not total more than Allowable Expenses.

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

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

- the Other Plan has a rule coordinating its benefits with those of This Plan and such rule states that benefits of the Other Plan will be determined after those of This Plan; and
- the order of benefit determination rules require This Plan to determine benefits before those of the Other Plan.

Order of Benefit Determination Rules

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

a. Non-Dependent/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, except that:

- if the person is also a Medicare beneficiary and,
- if the rule established by the Social Security Act of 1965 as amended makes Medicare secondary to the Plan covering the person as a dependent of an active Employee, then the order of benefit determination shall be:

  – benefits of the Plan of an active Employee covering the person as a dependent;

  – Medicare;

  – benefits of the Plan covering the person as an Employee, Member, or Subscriber.

b. Dependent Child/Parents Not Separated or Divorced

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

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

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

c. Dependent Child/Separated or Divorced Parents

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

- first, the Plan of the parent with custody of the child;
- then, the Plan of the spouse of the parent with the custody of the child; and
- finally, the Plan of the parent not having custody of the child.

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

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

d. 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 hold 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 is ignored.

e. Continuation Coverage

If a person whose Coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:

- first, the benefits of a Plan covering the person as an Employee, Member, or Subscriber (or as that person's dependent);
- second, the benefits under the continuation Coverage.

If the Other Plan does not have the Rule described above, and if, as a result, the Plans do not agree on the order of benefits, this Rule is ignored.

f. Longer/Shorter Length of Coverage

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

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

The start of the new Plan does not include:

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

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

If the Other Plan does not contain provisions establishing the Order of Benefit Determination Rules, the benefits under the Other Plan will be determined first. However, if the Other Plan does contain provisions establishing the Order of Benefit Determination Rules but the Other Plan does not apply these Rules to specific Member claims (for example, prescription drug claims), the benefits under the Other Plan relating to these specific Member claims will be determined first.

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

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

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

- If This Plan is the Primary Plan, it will provide its benefits on a primary basis.
- If This Plan is the Secondary Plan, it will provide benefits first, but the amount of benefits and liability of This Plan will be limited to the benefits of a Secondary Plan.
- If the Non-complying Plan does not provide information needed to determine This Plan's benefits within a reasonable time after it is requested, This Plan will assume that the benefits of the Non-complying Plan are the same as the benefits of This Plan and provide benefits accordingly.
- If the Non-complying Plan reduces its benefits so that benefits received by You are less than those You would have received if the Non-complying Plan provided its benefits as the Primary Plan and This Plan provided its benefits as the Secondary Plan, then This Plan may advance the difference to You or on Your behalf. The benefits advanced shall not exceed the benefits This Plan would have provided if it had been the Primary Plan, less any benefits already provided as the Secondary Plan. In consideration of such advance, This Plan shall be subrogated to all of Your rights against the Non-complying Plan. Such advance shall also be without prejudice to any independent claims This Plan may have against the Non-complying Plan in the absence of such subrogation.

Section IX
Limitations/Exclusions

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

WAITING PERIOD

A Member will not be eligible to receive benefits until the Member has completed a Waiting Period of 60 days beginning with the Effective Date of the Member's Coverage.

PRIOR AUTHORIZATION

Some prescriptions drugs, and many Specialty Pharmacy Products, require Prior Authorization. For a current list of prescription drugs requiring Prior Authorization, call the telephone number shown on Your TRH Plan ID card. If Prior Authorization is not obtained, benefits may be reduced or denied. A Prior Authorization is not a guarantee of benefits. Benefits are based on all terms and conditions of the Coverage in force for the Member at the time Covered Services are provided.

QUANTITY LIMITATIONS

Some prescription drugs have quantity limitations. These limits are in keeping with the manufacturer's and the U.S. Food and Drug Administration's (FDA) recommendations and accepted medical practices. Prescriptions for drugs that have quantity limitations cannot be filled by the pharmacist in a greater amount than specified by the limitation. For a current list of prescription drugs with quantity limitations, call the telephone number shown on Your TRH Plan ID card.

LIMITATIONS

1. Drugs such as Fentanyl Citrate (Actiq and Fentora) are not covered when purchased through mail-order.

EXCLUSIONS

1. Medication not prescribed by a licensed practitioner who is authorized by law to prescribe a drug.
2. Services which the Administrator determines are not Medically Necessary or Medically Appropriate or which are Investigational as defined in Glossary.
3. Charges in excess of the Maximum Allowable Charge.
4. Prescription drugs purchased prior to the Effective Date of Coverage or after the Coverage is terminated.
5. Prescription drugs purchased during the Waiting Period.
6. Prescription drugs furnished without cost under the laws of any government except Medicaid (TennCare[SM]) coverage provided by the State of Tennessee.
7. Prescription drugs covered under Medicare Part B.
8. Prescription drugs for which You are not required or legally obligated to pay.
9. Any Charges for Prescription drugs for which Prior Authorization is required but not obtained.

10. Prescription drugs purchased while confined in a prison, jail or other penal institution or while in the custody of any government or law enforcement entity.

11. Prescription drugs prescribed by You.

12. Prescriptions dispensed by You or a member of Your immediate family.

13. Prescription drugs dispensed by Pharmacies other than a pharmacist unless otherwise specified in this Contract.

14. Prescription drugs paid under any other group, blanket or franchise insurance coverage, any group contract, other health insurance plan, union welfare plan, or labor-management trust plan.

15. Telephone or e-mail consultations, charges for writing or calling in Prescription Drugs, depositions, testimony or court related fees, handling fees, postage, shipping, mail charges or sales tax.

16. Charges for administration of medication.

17. Immunizations and vaccinations, including but not limited to, shots for traveling outside of the United States and except as otherwise specified in this Contract. Administration charges for Non-Covered immunizations and vaccinations are not Covered Charges.

18. Prescription drugs designed to enhance a Member's level of fertility in the absence of a disease state, create a pregnancy, or improve conception quality.

19. Prescription drugs primarily for cosmetic purposes or the change or improve appearance (for example, anti-wrinkle or hair regrowth).

20. Prescription drugs for the treatment of bulimia, anorexia or other eating disorders.

21. Prescription drugs for the treatment of obesity or morbid obesity. Prescription drugs due to the rendering of or failure to render treatment for obesity or morbid obesity.

22. Whole blood, blood components, and blood derivatives.

23. Over-the-counter drugs (not requiring a prescription), unless required by law or specifically designated as covered under this Plan; nutritional supplements, dietary supplements, vitamins, except those which by law require a prescription; and/or prescription drugs dispensed in a doctor's office. Medical supplies that can be obtained without a prescription (except for diabetic supplies) including, but not limited to, adhesive bandages, dressing material for home use, antiseptics, medicated creams and ointments, cotton swabs, and eyewash.

24. Prescription drugs which have an over the counter equivalent.

25. Provider administered Specialty Pharmacy Products.

26. Prescription drugs dispensed in a physician's office, hospital or other medical facility, including allergy injections.

27. Court-ordered treatment with prescription drugs, unless benefits are otherwise payable.

28. Maintenance medications when used for substance abuse disorders (including, but not limited to, Methadone and Buprenorphine).

29. Prescription drugs for treatment of sexual dysfunction, including but not limited to erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido (such as Viagra, Cialis, etc.).

30. Nicotine replacement therapy and aids to smoking cessation including, but not limited to, patches and prescription drugs.

31. Prescription drugs intended to terminate a pregnancy including, but not limited to RU-486.
32. Provider administered contraceptives.
33. Durable medical equipment, prescription devices, prosthetic appliances and orthotics, including, but not limited to cranial orthosis, cranial prosthesis, foot orthotics.
34. Therapeutic services.
35. Prescription drugs purchased outside of the United States, unless approved by the Plan.
36. Lovaza.
37. Services not listed in this Contract as a Covered Service.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY AND KEEP ON FILE FOR REFERENCE.

LEGAL OBLIGATIONS

Tennessee Rural Health Improvement Association (TRH Health Plans or "TRH") is required by law to maintain the privacy of all medical information within its organization; provide this notice of privacy practices to all Members; inform Members of its legal obligations; advise Members of additional rights concerning their medical information; and to notify affected Members following a breach of unsecured Protected Health Information ("PHI"). TRH must follow the privacy practices contained in this notice from its **effective date of September 23, 2013**, and continue to do so until this notice is changed or replaced.

TRH reserves the right to change its privacy practices and the terms of this notice at any time, provided applicable law permits the changes. Any changes made in these privacy practices will be effective for all medical information that is maintained including medical information created or received before the changes were made. All Members will be notified of any changes by receiving a new notice of privacy practices.

You may request a copy of this notice of privacy practices at any time by contacting Ryan D. Brown, TRH, Chief Compliance and Privacy Officer, P.O. Box 313, Columbia, TN 38402-0313.

AFFILIATED ENTITIES COVERED BY THIS NOTICE

This notice applies to the privacy practices of the following affiliated covered entities that may share Your Protected Health Information as needed for the purposes of treatment, payment, and health care operations: Tennessee Rural Health Improvement Association ("TRH") and its subsidiaries, TRH Health Insurance Company and RH Group Services, Inc.

USES AND DISCLOSURES OF MEDICAL INFORMATION

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

TREATMENT: Your medical information may be disclosed to a doctor or hospital that requests it to provide treatment to You or for disease and case management programs.

PAYMENT: Your medical information may be used or disclosed to pay claims for services which are covered under Your health care Coverage.

HEALTH CARE OPERATIONS: Your medical information may be used and disclosed to determine Practitioner, conduct quality assessment and improvement activities, to engage in care coordination or case management, to pursue Right of Recovery and Reimbursement/Subrogation, accreditation, conducting and arranging legal services, underwriting and rating, and for other administrative purposes. TRH cannot use or disclose Your genetic medical information for underwriting purposes unless You apply for long term care coverage.

AUTHORIZATIONS: You may provide written authorization to use Your medical information or to disclose it to anyone for any purpose. You may revoke this authorization in writing at any time but this revocation will not affect any use or disclosure permitted by Your authorization while it was in effect. TRH cannot use or disclose Your medical information for marketing purposes or make any disclosures of Your medical information that could constitute a sale of Protected Health Information unless You give written authorization. We must also disclose to You if TRH receives payment for Your medical information. Unless You give written authorization, We cannot use or disclose Your medical information, including psychotherapy notes, for any reason except those described in this notice.

PERSONAL REPRESENTATIVE: Your medical information may be disclosed to You or to a family Member, friend or other person to the extent necessary to assist with Your health care or with payment for Your health care but only if You agree We may do so or if they have the legal right to act for You, as described in the Individual Rights section of this notice.

UNDERWRITING: Your medical information may be received for underwriting, Practitioner rating or other activities relating to the creation, renewal, or replacement of health care coverage or benefits. If TRH does not issue that health care Coverage, Your medical information will not be used or further disclosed for any purpose, except as required by law.

RESEARCH: Your medical information may be used or disclosed for research purposes provided that certain established measures to protect Your privacy are in place.

HEALTH RELATED COMMUNICATIONS WITH YOU: Your medical information may be used to contact You with information about health-related benefits, services or treatment alternatives that may be of interest to You. Your medical information may be disclosed to a business associate to assist Us in these activities. Unless the information is provided to You by a general newsletter or in person or is for products or services of nominal value, You may opt-out of receiving further information by telling Us.

AS REQUIRED BY LAW: Your medical information may be used or disclosed as required by state or federal law. For example, We will use and disclose Your PHI in responding to court and administrative orders and subpoenas, and to comply with workers' compensation laws. We will disclose Your PHI when required by the Secretary of Health and Human Services and state regulatory authorities.

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

MATTERS OF PUBLIC INTEREST: Medical information may be released to appropriate authorities under reasonable assumption that You are a possible victim of abuse, neglect or

domestic violence or the possible victim of other crimes. Medical information may be released to the extent necessary to avert a serious threat to Your health or safety or to the health or safety of others. Medical information may be disclosed when necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody. Medical information may be disclosed for purposes of child abuse reporting.

MILITARY AUTHORITIES: Medical information of Armed Forces personnel may be disclosed to Military authorities under certain circumstances. Medical information may be disclosed to federal officials as required for lawful intelligence, counterintelligence, and other national security activities.

BUSINESS ASSOCIATES: From time to time We engage third parties to provide various services for Us. Whenever an arrangement with such a third party involves the use or disclosure of Your PHI, We will have a written contract with that third party designed to protect the privacy of Your PHI. For example, We may share Your information with business associates who process claims or conduct disease management programs on Our behalf.

INDIVIDUAL RIGHTS

You have the following rights. To exercise these rights, You must make a written request on Our standard form. To obtain the form, call the Privacy Office at 931-388-7872. Forms are also available at www.trh.com.

ACCESS: You have the right to receive or review copies of Your medical information, with limited exceptions. You may request a format other than photocopies, which will be used unless TRH cannot practicably do so. Any request to obtain access to Your medical information must be made in writing. You may obtain a form to request access by using the contact information at the end of this notice or You may send Us a letter requesting access to the address located at the end of this notice. If You request copies, there will be a charge of $ .25 per page and $10 for staff time to review, copy and prepare Your medical information, and postage if You want the copies mailed to You. If Your PHI is maintained in an electronic health record ("EHR") You also have the right to request that an electronic copy be sent to You or to another individual or entity. The fee for providing an electronic copy may not be greater than Our labor costs in responding to Your request for such a copy. If You request an alternative format, the charge will be cost-based for providing Your medical information in that format. For a more detailed explanation of the fee structure, please contact Our office using the information at the end of this notice. TRH requires advance payment before copying Your medical information.

ACCOUNTING: You have the right to receive an accounting of the disclosures of Your medical information made by TRH or by a business associate of TRH. This accounting will list each disclosure that was made of Your medical information for any reason other than treatment, payment, health care operations and certain other activities since April 14, 2003; however, if disclosures for purposes of treatment, payment, or health care operations were made through an EHR, You have the right to request an accounting for such disclosures made during the previous three years. This accounting will include the date the disclosure was made, the name of the person or entity the disclosure was made to, a description of the medical information disclosed, the reason for the disclosure, and certain other information. If You request an accounting more than once in a 12-month period, there may be a reasonable cost-based charge for responding to

these additional requests. For a more detailed explanation of the fee structure, please contact Our office using the information at the end of this notice.

DESIGNATION OF PERSONAL REPRESENTATIVE: You have the right to designate a family Member, friend or other person as Your personal representative. Your medical information may be disclosed to Your personal representative to the extent necessary to help with Your health care or with payment for Your health care. You may obtain a form to designate a personal representative by using the contact information at the end of this notice.

RESTRICTIONS ON DISCLOSURES: You have the right to request restrictions on TRH's use or disclosure of Your medical information. Generally TRH is not required to agree to these additional requests. You also have the right to request a limit on the medical information We communicate about You to someone who is involved in Your care or the payment for Your care. Any agreement to restrictions on the use and disclosure of Your medical information must be in writing and signed by a person authorized to make such an agreement on behalf of TRH; such restrictions shall not apply to disclosures made prior to granting the request for restrictions. TRH will not be bound unless the agreement is so memorialized in writing.

CONFIDENTIAL COMMUNICATIONS: You have the right to request confidential communications about Your medical information by alternative means or alternative locations. You must inform TRH that confidential communication by alternative means or to an alternative location is required to avoid endangering You. You must make Your request in writing and You must state that the information could endanger You if it is not communicated by the alternative means or to the alternative location requested. TRH must accommodate the request if it is reasonable, specifies the alternative means or location, and continues to permit Us to collect Practitioner and pay claims under Your health plan.

AMENDMENT: You have the right to request that TRH amend Your medical information. Your request must be in writing and it must explain why the information should be amended. TRH may deny Your request if the medical information You seek to amend was not created by TRH or for certain other reasons. If Your request is denied, TRH will provide a written explanation of the denial. You may respond with a statement of disagreement to be appended to the information You wanted amended. If TRH accepts Your request to amend the information, TRH will make reasonable efforts to inform others, including the people You name, of the amendment and to include the changes in any future disclosures of that information.

BREACH NOTIFICATION: You have the right to receive notice of a breach. We are required to notify You by first class mail or by e-mail (if You have indicated a preference to receive information by e-mail), of any breaches of unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the PHI unusable, unreadable, and undecipherable to unauthorized users. The notice is required to include the following information:

- A brief description of the breach, including the date of the breach and the date of its discovery, if known;
- A description of the type of unsecured PHI involved in the breach;
- Steps You should take to protect Yourself from potential harm resulting from the breach;

- A brief description of the actions We are taking to investigate the breach, mitigate losses, and protect against further breaches;
- Contact information, including a toll-free telephone number, e-mail address, web site, or postal address to permit You to ask questions or obtain additional information.

In the event the breach involves 10 or more patients whose contact information is out of date We will post a notice of the breach on the home page of Our web site or in a major print or broadcast media. If the breach involves more than 500 individuals in the state or jurisdiction, We will send notices to prominent media outlets. If the breach involves more than 500 individuals, We are required to immediately notify the Secretary of Health and Human Services. We also are required to submit an annual report to the Secretary of Health and Human Services of a breach that involves less than 500 individuals during the year and We will maintain a written log of breaches involving less than 500 patients.

If You receive this notice on the TRH web site or by any other electronic means, You may request a written copy of this notice by using the contact information at the end of this notice.

COMPLAINTS, QUESTIONS AND CONCERNS

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

If You are concerned that: (1) TRH has violated Your privacy rights; (2) You disagree with a decision made about access to Your medical information or in response to a request You made to amend or restrict the use or disclosure of Your medical information; (3) to request that TRH communicate with You by alternative means or at alternative locations, You may complain to Us using the contact information below. You may also submit a written complaint to the U.S. Department of Health and Human Services. The address to file a complaint with the U.S. Department of Health and Human Services will be provided upon request.

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

Privacy Office
TRH Health Plans
P.O. Box 313, Columbia, TN 38402-0313
Phone (931) 388-7872
E-mail: privacyoffice@trh.com

Tennessee Rural Health Improvement Association is a membership-based, not-for-profit organization which promotes the health of the rural people of Tennessee. Members can learn of the programs and services offered by TRH at their local Farm Bureau office.

9/2013