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TRH CONTRACT
CHILD COVERAGE
ADVANTAGE PLAN NGF
July 2015

Important Member Notifications

Women's Health and Cancer Rights Act of 1998

If a Member, in consultation with their Physician, decides to have reconstructive breast surgery after a mastectomy, the Member's Coverage includes benefits for certain services or supplies related to that reconstructive surgery. The Covered Services and supplies are:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and rebuilding of the other breast for a balanced appearance.
- Prosthesis and treatment of physical complications at all stages of mastectomy. This benefit includes Coverage for services related to treating swollen lymph glands.

Benefits will be subject to Deductible and Coinsurance Percentages. Benefits are subject to all Contract provisions.

Please read this Contract carefully and keep it in a safe place for future reference. If You have any questions about this Contract or any other matter related to Your membership in the Plan, please write or call:

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

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Introduction

We want You to understand and be satisfied with the terms of this Contract. The word "Coverage" is used to refer to the benefits available to the Member under the terms of this Contract. The words "You" and "Your" mean the Subscriber. The word "Member" means the eligible child enrolled under this Coverage.

Tennessee Rural Health Improvement Association ("TRH") is a membership based organization, which promotes health care for the rural people of Tennessee.

TRH, through its wholly owned subsidiary TRH Health Insurance Company ("TRH"), provides a program of health care benefits to its Members and Members of the Tennessee Farm Bureau Federation ("Farm Bureau"). This Contract replaces any Certificate, EOC, or Contract in effect prior to this Contract. A Benefit Exclusion Rider or rating classification attached to a previous Certificate, EOC, or Contract will apply to this Contract also. Any remaining Pre-Existing Condition Waiting Period from a previous Certificate, EOC, or Contract will apply to this Contract. This Coverage may be renewed by payment of the Charges.

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

ANY DISPUTE RELATED TO THIS COVERAGE WILL BE RESOLVED IN ACCORDANCE WITH THE GRIEVANCE PROCEDURE SECTION OF THIS CONTRACT.

To make it easier to read and understand this Contract, defined words are Capitalized. Those words are defined in the "Definitions" section of this Contract.

If the enrolled child is a new Member, and You are not satisfied with this Coverage, You can return this Contract to TRH within 30 days after You receive it. The Member's Coverage will terminate and any charges paid will be refunded (less any benefits paid). If the enrolled child is not a new Member or is transferring from another TRH Coverage to this Coverage, and You are not satisfied with this Coverage, You can return this Contract to TRH within 30 days after you receive it. The child's Coverage will terminate and any Charges paid for this Coverage will be refunded (less any benefits paid). The child's prior Coverage will not be reinstated.

If You have any questions when reading this Contract, please contact one of the customer service representatives at the number listed on the Member's Plan ID card or Your TRH Representative at Your local Farm Bureau office.

RIGHT TO RECEIVE AND RELEASE INFORMATION

You, on behalf of the Member, authorize and consent to TRH's receipt, use and release of the Member's personal information. Personal information includes, but is not limited to, any and all medical and dental records obtained, used or released in connection with administration of the Coverage and will be maintained and released in accordance with applicable state and federal laws and the TRH Notice of Privacy Practices. Such consent is deemed given by the signatures on the Application and Your acceptance of Coverage. Additional consent may be required whenever the Member obtains Covered Services under any TRH Contract. This authorization and consent remains in effect throughout the period the Member is covered under any TRH Contract until the Member reaches age 18. This authorization and consent survives the termination of the Coverage to the extent that such information or records relate to services rendered while the Member was covered under any TRH Contract and under the age of 18.

You may also be required to consent to the release of personally identifiable health information in connection with the administration of the Contract.

Because the Member is a minor, You agree to comply with the terms of this Contract on the Member's behalf.

RELATIONSHIP WITH NETWORK PROVIDERS

Independent Contractors

Network Providers are not employees, agents or representatives of TRH. Such providers contract with TRH, its affiliate, or a third party vendor and are paid for rendering Covered Services to Members. Network Providers are solely responsible for making all medical treatment decisions in consultation with their patients. TRH, its affiliate nor a third party vendor make medical treatment decisions under any circumstances.

TRH maintains authority to make all final determinations regarding the terms of this Coverage. Network Providers may dispute Coverage decisions. If the Network Provider 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 Providers' Participation

A provider's status as a Network Provider may change at any time. A Network Provider may also limit the number of Members he, she or it will accept as patients. The Plan does not promise that any specific Network Provider will be available to render services while the Member is Covered.

Ryan Brown

Corporate Secretary

Section I
Network Providers

To receive maximum benefit from this Coverage, the Member's provider must be a member of the provider network shown on the Member's Plan ID Card. Before a Member receives health care services, check to be sure that the health care provider is a member of the network. You may also obtain the current directory of Network Providers by calling the toll free number on the Member's Plan ID card.

MEMBER/PROVIDER RELATIONSHIP

The choice of a provider is solely the decision of You and/or the Member.

The Plan does not furnish Covered Services. The Plan is not liable for any act or omission of any provider. The Plan bears no responsibility for a provider's failure or refusal to provide Covered Services to a Member.

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

The Plan cannot be held responsible for any injuries or damage caused by negligence or malpractice by a provider.

NETWORK PROVIDER

A Network Provider is a Physician, Hospital, pharmacy, or other Eligible Provider that has contracted with TRH, its affiliate, or a third party vendor to furnish Covered Services and to accept the Plan's payment, plus applicable Deductibles and Coinsurance as payment in full for Covered Services.

OUT-OF-NETWORK PROVIDER

An Out-of-Network Provider is a Physician, Hospital, pharmacy or other Eligible Provider that has not contracted to furnish Covered Services and to accept the Plan's payment, plus applicable Deductibles and Coinsurance as payment in full for Covered Services.

NON-CONTRACTED PROVIDER

A Non-Contracted Provider is a provider of Covered Services in a specialty category or type which does not contract to provide Covered Services.

CENTER OF EXCELLENCE

A facility that has contracted to provide transplant services for specific organ and/or bone marrow transplant procedures covered under the terms of this Contract. Not all Network Providers are Centers of Excellence.

SPECIALTY PHARMACY NETWORK

The Specialty Pharmacy Network is a network of pharmacies which have contracted to provide Specialty Pharmacy Products to Members. Pharmacies that are Network Pharmacies for prescription drugs may not be a part of the Specialty Pharmacy Network.

Section II
Definitions

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

Acute - an illness or injury that is both severe and of short duration.

Advanced Radiological Imaging – services such as MRIs, MRAs, CAT scans, CT scans, PET scans, nuclear medicine and similar technologies.

Ambulance - a specially designed and equipped vehicle used only to transport the sick and injured which meets all applicable legal and licensing requirements.

Behavioral Health Care - Any services or supplies that are Medically Necessary and Medically Appropriate to treat a mental or nervous condition, alcoholism, chemical dependence, drug abuse, or drug addiction.

Benefit Exclusion Rider - an attachment to this Contract excluding benefits for the Member for the listed conditions. A Benefit Exclusion Rider will remain in effect until the Benefit Exclusion Rider termination date specified on the underwriting decision letter. The underwriting decision letter will serve as the only notification regarding the removal of the Benefit Exclusion Rider. A Benefit Exclusion Rider will be applied independently from and in addition to the Pre-Existing Condition Waiting Period.

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

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.

Care Management – a program that promotes cost effective coordination of care for Members with complicated medical needs, Chronic illnesses, and/or catastrophic illnesses or injuries. This process links individual Members and families with the appropriate medical services and community resources necessary to manage the Member's total care to promote optimum quality and optimum outcomes. Care management involves a systematic process of assessing, planning, service coordination and monitoring through which multiple health needs of patients are met.

Center of Excellence - A facility that has contracted to provide transplant services for specific organ and/or bone marrow transplant procedures covered under this Plan. For example, some Centers of Excellence might contract to perform heart transplants, but not liver transplants. Not all Network Providers are Centers of Excellence.

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

Child Health Supervision - routine visits to a pediatrician or other qualified provider to include Medically Necessary and Medically Appropriate periodic health screenings, immunizations and injections for children through the age of 6 years.

Chronic – lasting for a long period of time or recurring frequently.

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

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

Coinsurance Percentage - the percentage of the Maximum Allowable Charge that will be paid for a Covered Service during a Calendar Year after a Member satisfies Deductible. The Coinsurance Percentage is shown in the Schedule of Benefits.

Complications of Pregnancy - Complications of Pregnancy, as defined by Tennessee state law, means conditions, requiring Hospital confinement when the pregnancy is not terminated, whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as Acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity. Complications of Pregnancy also includes non-elective cesarean 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, similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy or a live birth cesarean section.

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 ("FDA") and which contains at least one ingredient classified as a legend prescription drug.

Concurrent Review - the determination of whether continued inpatient or outpatient care, or a given level of service, is Medically Necessary and Medically Appropriate.

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

Cosmetic Services – services or supplies, including surgery and drugs, intended to alter or reshape the body for the purpose of improving appearance.

Covered Service, Coverage - Medically Necessary and Medically Appropriate services or supplies specified in this Contract for which benefits may be available. Covered Services are subject to all the terms, conditions, exclusions and limitations of this Contract.

Custodial Care - care provided primarily for maintenance designed to assist the patient in activities of daily living, such as convenience and hygiene services. It is not provided primarily for its therapeutic value in treatment of an illness or injury. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets, and supervision of self-administration of medication not requiring constant attention of medical personnel.

Custodial Care includes services that the Medical Director determines are not effective or will not result in improvement in the Member's medical condition or long-term health.

Deductible - the dollar amount of Covered Services that must be incurred by and paid by or on behalf of a Member each Calendar Year before benefits are payable for all or part of the remaining Covered Services. Any balance of Charges (between Billed Charges and the Maximum Allowable Charge) required for services will not be considered when determining if the Member has satisfied a Deductible.

The amount applied to the Deductible will apply to the Network Out-of-Pocket Maximum.

Durable Medical Equipment - equipment which:

- can only be used to serve the medical purpose for which it is prescribed;
- is not useful to the patient or other person in the absence of illness, injury or disability;

- is able to withstand repeated use; and
- is appropriate for use within the home.

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

Effective Date - is the date on which Coverage of a Member begins under this Plan.

Eligible Dependent - A spouse or child who has been approved for Coverage on this Plan. Refer to the Eligibility section of this Contract for complete details.

Eligible Provider – A person or entity that is engaged in the delivery of health services that is licensed, certified, or practicing in accordance with applicable state or federal laws. An Eligible Provider is a provider that has been approved by the Plan. Eligible Providers include:

Hospital – a licensed short-term, Acute care facility which provides inpatient services and is compensated by or on behalf of its patients. A Hospital must provide surgical and medical facilities primarily to diagnose, treat and care for the injured and sick; have a staff of Physicians licensed to practice; and provide 24-hour nursing care by registered nurses. A facility which serves, other than incidentally, as a nursing home, Custodial Care home, health resort, rest home, rehabilitation facility, or place for the aged is not considered a Hospital.

Other Facility Providers – a facility that is licensed to perform Covered Services in the state where such services are provided. Other Facility Providers include, but are not limited to, the following:

– Behavioral Health Care Facility
– Ambulatory Surgical Facility
– Contracted Transplant Facility
– Licensed Birthing Center
– Freestanding Dialysis Facility
– Residential Treatment Facility
– Skilled Nursing Facility
– Substance Abuse Treatment Facility
– Other facilities approved by the Medical Director and licensed to provide Covered Services

Physician – a licensed practitioner legally entitled to practice medicine and perform surgery. Such practitioner must be licensed in Tennessee or in the state in which Covered Services are rendered and must provide services within the scope of his/her licensure. All services rendered must fall within the providers' specialty and be those normally rendered by a provider within this specialty or degree.

Other Professional Providers – Other Professional Providers may provide services covered by this Contract. To be eligible, a provider must be licensed or certified in Tennessee or in the state in which Covered Services are rendered; provide services within the scope of his/her licensure; practice in accordance with applicable state and federal laws; and be approved by Us. All services rendered must fall within the providers' specialty and be those normally rendered by a provider within this specialty or degree. All services and supplies must be rendered by the provider actually billing for them. Other Professional Providers include, but are not limited to, a nurse midwife, advance practice nurse, and Physician assistant.

Other Providers – other providers of Covered Services include, but are not limited to, the following:

– Durable Medical Equipment suppliers
– certified Ambulance service
– Hospice
– Pharmacy
– Home Health Care

– suppliers of oxygen

Emergency - the sudden onset of a 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 the absence of immediate medical attention, could potentially result in:

- placing the person's health in serious jeopardy;
- serious impairments to bodily functions;
- serious dysfunction of any bodily organ or part; or
- other serious medical consequences.

Emergency Room Deductible - an additional Deductible applied to each visit to an Emergency room. This amount is in addition to the Calendar Year Deductible and does not count toward the Out-of-Pocket Maximum.

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

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

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

- **Approved Hospice** refers to a Hospice that:
  - is licensed by and, if legally required, has been issued a Certificate of Need from the state in which it is operating,
  - is certified as a Home Health Care Agency under Title XVIII and Title XIX of the Social Security Act,
  - is eligible for accreditation by the Joint Commission on Accreditation of Healthcare Organizations as a Hospice, and
  - provides in-home health care services which conform to the standards of a Hospice Program of Care as adopted by the Board of Directors of the National Hospice Organization.
- **Contracting Hospice** means an Approved Hospice licensed in Tennessee that has contracted with TRH, its affiliate, or a third party vendor.

Hospice Care - Medically Necessary and Medically Appropriate medical services rendered to a terminally ill patient where life expectancy is 6 months or less. Services must be provided by a Physician-supervised team of professionals and volunteers on 24-hour call. Bereavement services to the family must be available.

Investigational Services - a drug, device, treatment, therapy, procedure, or other service or supply that does not meet the definition of Medical Necessity or:

- Cannot be lawfully marketed without approval of the Food and Drug Administration ("FDA") when such approval has not been granted at the time of its use or proposed use, or
- Is the subject of a current Investigational new drug or new device application on file with the FDA, or
- 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

- 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
- 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
- The Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research within HHS has determined that the service or supply is either experimental or Investigational or that there is insufficient data to determine if it is clinically acceptable, or
- In the predominant opinion of experts, as expressed in the published authoritative literature, that usage should be substantially confined to research settings, or
- 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
- The service or supply is required to treat a complication of an experimental or Investigational Service.

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

- the Member's medical records, or
- the protocol(s) under which proposed service or supply is to be delivered, or
- any consent document that the Member has executed or will be asked to execute, in order to receive the proposed service or supply, or
- 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 the Member, or
- regulations and other official publications issued by the FDA and HHS, or
- the opinions of any entities that contract with TRH, its affiliate, or a third party vendor to assess and coordinate the treatment of Members requiring non-Investigational Services.

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

Maximum Allowable Charge (MAC) - the amount the Plan has determined to be the maximum amount payable for a Covered Service. That determination will be based upon the contract with a Network Provider or the amount payable based on the fee schedule for the Covered Services when rendered by Out-of-Network Providers.

Medical Director - a Physician designated by the Plan, or that Physician's designee, who is responsible for the administration of the medical management programs.

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:

- be Medically Necessary.
- be used to diagnose or treat a Member's condition caused by disease, injury or congenital malformation.

- be consistent with current standards of good medical practice for the Member's medical condition.
- be provided in the most appropriate site and at the most appropriate level of service for the Member's medical condition.
- on an ongoing basis, have a reasonable probability of:
  - correcting a significant congenital malformation or disfigurement caused by disease or injury.
  - preventing significant malformation or disease.
  - substantially improving a life sustaining bodily function impaired by disease or injury.
- not be provided solely to improve a Member's condition beyond normal variations in individual development and aging including:
  - comfort measures in the absence of disease or injury.
  - improving physical appearance that is within normal individual variation.
- not be for the sole convenience of the provider or Member.

Medically Necessary or Medical Necessity – services which have been determined by the Plan to be of proven value for use in the general population. To be Medically Necessary a service must:

- have final approval from the appropriate government regulatory bodies.
- have scientific evidence permitting conclusions concerning the beneficial effect of the service on health outcomes.
- improve the net health outcome.
- be as beneficial as any established alternative.
- demonstrate the improvement outside the Investigational setting.

Member - the eligible child who is enrolled and covered under this Contract.

Network Pharmacy - a pharmacy that has entered into a Network Pharmacy Agreement with TRH, its affiliate, or a third party vendor to legally dispense prescription drugs to Members, either in person or through home delivery. This does not include the Specialty Pharmacy Network.

Network Provider – an Eligible Provider that has contracted with TRH, its affiliate, or a third party vendor to furnish Covered Services to Members and to accept the Plan's payment, plus applicable Deductibles and Coinsurance as payment in full for Covered Services.

Non-Contracted Providers - a provider that renders Covered Services to Members, but is in a specialty category or type with which TRH, its affiliate, or a third party vendor has not contracted to provide Covered Services.

Non-Covered Service - a service or supply for which no benefits are available.

Out-of-Network Pharmacy – a pharmacy that has not contracted with TRH, its affiliate, or a third party vendor to legally dispense prescription drugs to Members.

Out-of-Network Provider – an Eligible Provider that has not contracted with TRH, its affiliate, or a third party vendor to furnish Covered Services to Members and to accept the Plan's payment, plus applicable Deductibles and Coinsurance as payment in full for Covered Services.

Out-of-Pocket Maximum - the dollar amount which a Subscriber or Member is responsible to pay for Covered Services during a Calendar Year.

This maximum can be satisfied by Charges for Covered Services provided by Network Providers. This does not include services or Charges which exceed the Maximum Allowable Charge. Charges for Covered Services received from an Out-of-Network Provider will not apply to this maximum and will be limited to the Coinsurance Percentage listed in the Schedule of Benefits. Deductible and Coinsurance applied to the Emergency Room Deductible do not apply to this maximum.

When the applicable Out-of-Pocket Maximum for Covered Services is reached, 100% of the Maximum Allowable Charge is payable for other Covered Services received from a Network Provider during the remainder of the Calendar Year.

Pre-Existing Condition - an illness, injury, pregnancy or any other medical condition which existed at any time preceding the Effective Date of Coverage under this Contract for which:

- medical advice or treatment was recommended by, or received from a provider of health care services; or
- symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment.

Pre-Existing Condition Waiting Period - that period of time during which no benefits are available for a Pre-Existing Condition. It begins on the Effective Date of Coverage. If this Contract replaces another certificate or Contract, the Effective Date of Coverage is the date first covered under the prior certificate or Contract.

Prior Authorization – The purpose of Prior Authorization is solely to ensure that patients receive services at the appropriate time and in the appropriate setting. A Prior Authorization is not a guarantee of benefits. It is a review conducted prior to delivery of certain services, to determine if such services will be considered Covered Services. 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 which has contracted with TRH, its affiliate, or a third party vendor to provide Specialty Pharmacy Products to Members.

Subscriber - a TRH Member who is the biological parent, adoptive parent, step-parent or legal guardian of a Member who has satisfied the eligibility requirements and has been enrolled for Coverage under this Plan.

Transplant Maximum Allowable Charge (TMAC) - The amount TRH has determined to be the maximum amount payable for a transplant procedure. Maximum Allowable Charge will be based upon TRH, or its affiliate or third party vendor's, contract with a provider or the amount payable based on TRH's, or its affiliate or third party vendor's, fee schedule for the Covered Services when rendered by an Out-of-Network Providers.

TRH Health Plans, We, Us, Our or the Plan– Tennessee Rural Health Improvement Association.

Section III
Eligibility

This Contract describes the benefits available to an Eligible Child under the terms of this health care program. You are called the Subscriber. The Eligible Child is called the Member.

The Subscriber must be a member of their local Tennessee Farm Bureau and TRH.

A child is eligible for this Coverage if he/she:

1. meet TRH medical underwriting requirements; and
2. meets any additional requirements established.

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

ELIGIBLE CHILD DEFINED

The following will be considered Eligible Child under this Coverage:

1. Your biological child who is under the age of 19.

2. Your adopted child who is under the age of 19.

   To establish eligibility, a complete copy of the Final Order of Adoption must be provided at the time of application for Coverage for such adopted child.

3. Your stepchild who is under the age of 19.

   To establish eligibility, a complete copy of documentation establishing parentage must be provided at the time of application for Coverage for such stepchild.
   A foster child or a child for whom You are legal guardian (not a biological child, adopted child, or stepchild) will not be considered an Eligible Child under the terms of this Contract.

4. A child for whom You or Your spouse are legal guardian. The child must be under the age of 26.

   To establish eligibility, a complete copy of the court order must be provided.

TRH reserves the right to request proof of continuing eligibility at any time.

WHEN A CHILD LOSES ELIGIBILITY

Once the Member no longer meets the Eligible Child requirements, this Contract will be terminated effective the last day of the period for which Charges have been paid.

Upon attaining age 19, the Member will be offered comparable coverage, provided the Member completes a transfer application within 60 days of the Member's 19th birthday. The Member will be issued a new Contract and Plan ID card. Deductibles and Coinsurance paid for the current Calendar Year will be applied to the new coverage for the remainder of the Calendar Year.

You must notify TRH immediately of any change in the eligibility status of a child. Failure to immediately notify TRH of a change in the eligibility status of any member will be considered fraud.

Section IV
General Provisions

BENEFITS TO WHICH A MEMBER IS ENTITLED

Subject to the terms of this Contract, Members are entitled to benefits for Covered Services in the amounts shown in the Schedule of Benefits.

Benefits are provided only for Covered Services received on or after the Member's Effective Date and prior to the Member's termination date. Benefits are provided for covered inpatient services only if the Member's admission occurs on or after his or her Effective Date subject to all provisions of this Contract.

THE PLAN IDENTIFICATION (ID) CARD

You should show the Member's Plan ID card to health care providers at the time of service.

Be sure to show the Physician the Member's Plan ID card whenever hospitalization is recommended. Tell the Physician that Prior Authorization is required in the Member's health care benefits plan. The Member's Plan ID card contains special instructions on how to initiate the review process.

Carry the Member's Plan ID card at all times. In case of loss, the Member can still use his or her Coverage. We can replace the Member's card more quickly, however, if You know the Member's identification number.

Legal requirements govern use of the Member's card. You cannot let anyone else use the Member's card. Nor can You let anyone else us the Member's benefits or receive payment for them.

THE CONTRACT

This Contract explains the benefits available to Members under the Plan. This Contract cannot be transferred or assigned to another party. If a change occurs to the terms of this Contract, You will be given at least 30 days written notice before the change takes effect. Continued payment of the Charges indicates acceptance of the change.

You agree:

- That any notice will be binding if mailed to You at the address last shown in TRH's records. **It is Your responsibility to maintain the Member's current address on file with the Plan at all times.**
- That Coverage is binding only if all statements made on the application are true and correct. However, a rescission of Coverage may occur only in the event of fraud or intentional misrepresentation.
- To comply with the terms of the Contract.

CONTINUITY OF CARE

When a Network Provider becomes an Out-of-Network Provider, benefits will be available as if such provider were still a Network Provider:

- for up to 120 days, provided the Member was under active treatment for a particular illness or injury on the date the provider became an Out-of-Network Provider and Covered Services are for the same illness or injury; or
- until discharge, if the Member was under treatment at an inpatient facility on the date the provider became and Out-of-Network Provider.

The now Out-of-Network Provider must agree to continue to provide Covered Services on the same terms and conditions as a Network Provider.

Section V
Billing of Charges & Termination of Coverage

SCHEDULE OF CHARGES

The rates for the Coverage provided in this Contract may be changed by providing You notice of change at least thirty (30) days prior to the Effective Date of such change.

The Member's Coverage is age rated. The Member's rates will automatically change on the first billing date after the Member moves to a different age bracket.

PAYMENT OF CHARGES

Payment of Charges for Coverage must be submitted to TRH. TRH will retain seven years of Your billing and Charges paid history.

If the Member's Coverage is paid by monthly bank draft and the draft is dishonored (returned unpaid) by Your bank of record for any reason, such dishonor could result in forfeiture of Coverage. A 10-day grace period is allowed if Charges are paid on a monthly basis. This means that each Charge will be accepted within 10 days after its due date. If it is not paid within the grace period, Coverage ends on the due date. Coverage will automatically be cancelled if You fail to pay the Charges within the grace period.

FEE FOR DEFAULT OF PAYMENT

Should Your payment of Charges be dishonored (returned unpaid) by Your bank of record for any reason, You will be responsible for default fees in the amount of $25. This default fee will be waived if the Member's Coverage has not experienced a defaulted payment in the previous 12 months. TRH reserves the right to change the default fee amount at any time.

CHANGES TO COVERAGE

You, as a Subscriber, can request a change to the Member's Coverage. Your request is subject to approval by TRH and must be made in writing to TRH 10 days prior to the next Charges due date.

TERMINATION OF COVERAGE

This Coverage may be terminated if:

- Payment of Charges for the Member's Coverage is not received when it is due; or
- You fail to pay Your Farm Bureau or TRH membership dues; or
- You, or the Member, fail to cooperate with TRH as required by this Contract; or
- You, or the Member, have made a material misrepresentation or committed fraud against TRH. This provision includes, but is not limited to, furnishing incorrect or misleading information, failing to provide accurate information or permitting the improper use of the Member's Plan ID card; or
- You, or the Member, act in such a disruptive manner as to prevent or adversely affect Our ability to administer the Member's Coverage under the terms of this Contract; or
- You request that the Coverage be terminated; or
- The Member has resided outside the United States for 24 consecutive months; or
- This TRH plan is terminated.

You, as a Subscriber, can cancel the Coverage for any reason by giving TRH written notice 10 days prior to the next Charges due date.

If Coverage terminates as a result of the Member's death, Coverage ends on the date of death and You are entitled to a refund of any unused Charges.

If You are on a monthly bank draft, You have the option to stop payment at Your bank, provided You present Your bank with the proper account information and exact bank draft amount.

TRH may cancel this Coverage for any of the reasons described herein by giving written notice to You 30 days prior to the date of termination. Such written notice will be binding if mailed to You at the address last shown in the Plan's records. It is Your responsibility to maintain the Member's current address on file with the Plan at all times.

RESTORATION OF COVERAGE

Restoration of Coverage may be available to You if the Member's Coverage has terminated due to non-payment of Charges within the grace period as described in "Schedule of Charges". Payment of the total Charges due, including any applicable default fees, in addition to a fee of $100 must be received by TRH within 10 days of the final day of Your grace period to restore the Member's Coverage.

FINANCE CHARGE AND LEGAL ACTION

In the event Coverage is terminated back to the last Charges due date, the Plan may recoup the amount of any benefits paid since that date.

In the event Coverage is terminated back to the original Effective Date, the Plan may recoup the amount that any benefit payments exceed the Charges paid. If such amounts cannot be recouped from the providers, the Member will be responsible for reimbursement.

The Plan may impose a finance charge of 1 ½ % per month to such amount not remitted to the plan within 30 days of the date of notification of the amount due.

The Plan has the right to recover any expenses incurred in the attempt to collect any amount owed the Plan. Such expenses include collection fees, court costs, attorney's fees and other associated costs.

REFUNDS

In the event a refund of Charges is due, TRH will make the refund payable to the payor of the Coverage, as the Subscriber and payor are not always the same person. A cover letter explaining the refund will be mailed to the payor. You, as the Subscriber, will receive a copy of the refund explanation letter.

Section VI
Schedule of Benefits

BENEFITS AVAILABLE

A Member is entitled to benefits for Covered Services as specified in this Schedule of Benefits. Benefits shall be determined according to the 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 does a Member acquire a vested interest in continued receipt of a particular benefit or level of benefit.

CALCULATION OF COINSURANCE

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

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

MEMBER'S RESPONSIBILITY

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 required for certain services, which are listed in the Cost Containment and Medical Management Section of this Contract. Please have the Member's Physician call the telephone number shown on the Member's Plan ID card before services are provided. Otherwise, the Member's 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 services are provided.

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 Provider or Non-Contracted Provider which exceed the Maximum Allowable Charge will be the responsibility of the Member.

Coinsurance Percentages	Network Provider Services	Out-of-Network Provider Services
Covered Services	**80% of the Maximum Allowable Charge after Deductible**	**60% of the Maximum Allowable Charge after Deductible**

Emergency Room Deductible	Network Provider	Out-of-Network Provider
Additional Deductible for Each Emergency Room Visit (If patient not admitted)	**$75**	**$75**
The Emergency Room Deductible is separate and in addition to the Calendar Year Deductible. The Emergency Room Deductible will be applied to each Emergency Room visit.		

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

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

TRANSPLANT SCHEDULE OF BENEFITS	
Centers of Excellence	**80%** of the Transplant Maximum Allowable Charge (TMAC) after the Deductible is met. Network Out-of-Pocket Maximum applies. The Member will not be responsible for amounts over TMAC.
Network Providers (Not Centers of Excellence)	**80%** of the Transplant Maximum Allowable Charge (TMAC) after the Deductible is met. Network Out-of-Pocket Maximum applies. Amounts over TMAC do not apply to the Out-of-Pocket Maximum and are not covered. The Member may be responsible for amounts over TMAC.
Out-of-Network Providers	**60%** of the Transplant Maximum Allowable Charge (TMAC) after the Deductible is met. Out-of-Pocket Maximums do not apply. Amounts over TMAC are not covered. The Member will be responsible for amounts over TMAC.

All transplants require Prior Authorization. Benefits will be denied without Prior Authorization. **Centers of Excellence are different from Network Providers for other services. Not all Network Providers are Centers of Excellence.**

Call the Claims Administrator's customer service department before any pre-transplant evaluation or other transplant service is performed to request authorization and to obtain information about Centers of Excellence. Network Providers that are not Centers of Excellence may bill the Member for amounts over the Transplant Maximum Allowable Charge (TMAC). Amounts over the Transplant Maximum Allowable Charge will not be covered by the Plan.

CHILD HEALTH SUPERVISION SERVICES

Benefits are available for a Member under 7 years of age for physical examinations and appropriate immunizations/vaccinations rendered by a Network Provider. Services include history, physical exam, developmental assessment, anticipatory guidance, and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards. No benefit is available for the examinations and immunizations if provided by an Out-of-Network Provider.

Benefits for physical examinations are subject to the following guidelines:

Under age one: 4 exams from birth to the child's first birthday

Age one: 2 exams from the child's first birthday to the child's second birthday

Age two through six: *1 exam per year

*The Member's birthday determines when a year begins and ends.

Exams not used during these time periods do not carry over to the next time period.

Immunizations, vaccinations and booster shots recognized as appropriate for Child Health Supervision are eligible and include:

Diphtheria, Tetanus, Pertussis (DPT)
Haemophilus influenza type B (HIB)
Hepatitis A
Hepatitis B
Inactivated Poliovirus
Influenza
Measles, Mumps, Rubella (MMR)
Meningococcal
Pneumococcal
Rotavirus
Varicella

Section VIII
Member Benefits

This Coverage provides benefits for many medical services and supplies received by a Member. However, not all medical expenses are covered. It is important for You, on behalf of the Member, to understand which services are covered by this Contract. You also need to remember how the Cost Containment and Medical Management features can affect the Member's benefits as Prior Authorization is required for certain services.

Most health care Coverage contains specific benefit maximums, limitations and exclusions. The benefit maximums, limitations and exclusions that apply to this Coverage are outlined in the Limitations/Exclusions Section, in the Schedule of Benefits section and in this Member Benefits section**.**

Benefits will be provided under this Coverage only for services or supplies which are Medically Necessary and Medically Appropriate and performed and billed by an Eligible Provider. Services must be related to the diagnosis and/or treatment of the Member's illness or injury.

Benefits for each expense are subject to the Deductible. Coinsurance will be a percentage of the Maximum Allowable Charge as stated in the Schedule of Benefits. The portion of any Charge for a service or supply which is more than the Maximum Allowable Charge amount will not be considered covered. Charges billed by an Out-of-Network Provider or a Non-Contracted Provider which exceed the Maximum Allowable Charge will be the responsibility of the Member.

Allergy Testing

Benefits are available for Medically Necessary and Medically Appropriate allergy testing.

Ambulance

Benefits are available, subject to Deductible and Coinsurance, up to a maximum of $450, per occurrence, for a ground Ambulance to transport the Member:

- from the Member's home or the scene of an accident or Emergency to the nearest Hospital where appropriate medical or surgical services are available;
- between Hospitals; or
- between a Hospital and a Skilled Nursing Facility.

Benefits are available for air or sea Ambulance, subject to Deductible and Coinsurance, up to a maximum of $5,000, per occurrence, from one location to another where:

- the Member's medical condition requires immediate transport that could not be provided by local ground Ambulance; or
- the point of pick up is not accessible by land vehicle; or
- the Member's medical condition is such that the time needed to transport poses a threat to his or her health.

Benefits will <u>not</u> be available under this Coverage for:

- Charges for dispatch of an Ambulance that is not used by the Member;
- transport to a Physician's office, outpatient department of a Hospital for medical care, or the patient's home; or
- Charges for waiting time or extrication.

Independent Ambulance providers are considered Non-Contracted Providers.

Anesthesia

Anesthesia administered by a Certified Registered Nurse Anesthetist (CRNA) or a Physician (other than the operating surgeon) provided the surgery is covered.

Assistant Surgeon

Services of an assistant surgeon who actively assists the operating surgeon in performing a covered surgical procedure, when:

- no intern, resident, or other staff doctor is available; and
- the surgical procedure requires the services of an assistant.

Behavioral Health Care Services

Benefits are available for Medically Necessary and Medically Appropriate inpatient/rehabilitative and outpatient treatment of mental health disorders 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. Benefits are also available for outpatient medication management.

Other levels of care may be substituted for inpatient days.

Prior Authorization is required for inpatient and intensive outpatient Behavioral Health Care Services.

Breast Reconstruction

Benefits are available for reconstructive breast surgery as a result of a mastectomy as well as surgery on the non-diseased breast needed to establish symmetry between the two breasts. Benefits are not available for reconstructive breast surgery as a result of a lumpectomy.

Post-mastectomy benefits are also available for:

- Breast prosthesis, surgical bras, or bras with an integrated prosthesis (combined limit of 5 per Calendar Year);
- Gel inserts, if Medically Necessary and Medically Appropriate; and
- Breast implants, if Medically Necessary and Medically Appropriate.

Cardiac Rehabilitative Services

Benefits are available for Medically Necessary and Medically Appropriate cardiac rehabilitative services for the treatment of cardiovascular disease. Prior authorization is required for inpatient and outpatient services. Outpatient services are limited to 36 visits per Calendar Year.

Chiropractic Services

Benefits are available for Medically Necessary and Medically Appropriate chiropractic services. Deductible and Coinsurance will apply.

Complications of Pregnancy

Benefits are available for Complications of Pregnancy, as defined by Tennessee state law, subject to Deductible and Coinsurance. Complications of Pregnancy means conditions, requiring Hospital confinement when the pregnancy is not terminated, whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as Acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity. Complications of Pregnancy also includes non-elective cesarean 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 or a live birth cesarean section.

Dental Services For Accidental Injury

Benefits are available under this Coverage only for dental work needed as the result of an Accidental Injury to the jaw, sound natural teeth, mouth or face. Covered Services must be performed within 12 months of the injury unless the medical records indicate the initial Medically Necessary and Medically Appropriate plan of treatment cannot be completed within 12 months of the injury. Such initial Medically Necessary and Medically Appropriate plan of treatment must be determined within 12 months of the injury. The accident must occur on or after the Effective Date of the Member's Coverage. An injury due to chewing or biting or received in the course of other dental procedures will not be considered an Accidental Injury.

Note: Under the terms of this Contract, Dentists (DDS, DMD) are Non-Contracted Providers. Charges billed by a Non-Contracted Provider which exceed the Maximum Allowable Charge will be the responsibility of the Member.

Dental Services - Anesthesia and Hospital

Benefits are available for anesthesia, as well as inpatient or outpatient Hospital expenses, in connection with a dental procedure if such procedure involves:

- dental surgery performed on a Member eight years of age or younger, where such procedure cannot safely be provided in a dental office setting; or
- mental illness or behavioral condition which precludes dental surgery in an office setting.

Note: Under the terms of this Contract, Dentists (DDS, DMD) are Non-Contracted Providers. Charges billed by a Non-Contracted Provider which exceed the Maximum Allowable Charge will be the responsibility of the Member.

Dental Services – Impacted Teeth

Benefits will be available for services and supplies for the surgical removal of impacted teeth. A Member's Coverage must be in effect for 12 months before this benefit is available.

Note: Under the terms of this Contract, Dentists (DDS, DMD) are Non-Contracted Providers. Charges billed by a Non-Contracted Provider which exceed the Maximum Allowable Charge will be the responsibility of the Member.

Diabetes Treatment

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

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

Services and supplies included under this provision shall include:

- blood glucose monitors, including monitors for the legally blind;
- test strips for blood glucose monitors;
- visual reading and urine test strips;
- injection aids;

- syringes and lancets;
- insulin pumps, infusion devices, and Medically Necessary and Medically Appropriate accessories;
- podiatric appliances for prevention of complications associated with diabetes;
- glucagon emergency kits; and
- insulin and oral hypoglycemic agents.

Diagnostic Services

When Medically Necessary and Medically Appropriate and ordered by an Eligible Provider to determine a specific condition or disease the following non-routine diagnostic services are covered:

- X-ray and other radiology services;
- laboratory and pathology services;
- cardiographic, encephalographic, and radioisotope test;
- prostate specific antigen (PSA) test;
- transrectal ultrasound for prostate cancer;
- mammograms; and
- pap smear.

Certain diagnostic services require Prior Authorization before services are rendered. For a list of diagnostic services requiring Prior Authorization, refer to the Cost Containment and Medical Management Section of this Contract.

Durable Medical Equipment

Benefits are available for the rental and, where deemed appropriate by the Plan, the purchase of manually operated Durable Medical Equipment when Medically Necessary and Medically Appropriate and prescribed by a Physician. Benefits for rental should not exceed the purchase price of the equipment.

Benefits are also available to fit, adjust, repair, or replace Durable Medical Equipment, provided the need for this arises from normal wear or the Member's physical development -- and not as a result of improved technology, loss, theft, or damage.

Hearing Aids

Benefits are available for each Member under 18 years of age for hearing aids prescribed by an audiologist or Physician. For the purpose of this benefit, hearing aid means any wearable, nonexperimental, nondisposable instrument or device designed for the ear and used to aid or compensate for impaired human hearing, including ear molds and services necessary to select, fit and adjust the hearing aid, but excluding batteries, cords, accessories, assistive listening devices, or implantable devices.

This hearing aid benefit is limited to $1,000 per individual hearing aid per ear every three years, subject to Deductible. The Coinsurance Percentage will be 100% up to the $1,000 maximum. Charges more than $1,000 will be the responsibility of the Member.

Home Health Care

Benefits are available for Medically Necessary and Medically Appropriate services and supplies authorized by the Plan and provided in a Member’s home by an agency who is primarily engaged in providing home health care services. Covered Services include: part-time, intermittent nursing care by a visiting R.N. or L.P.N.; home infusion (IV) therapy; and respiratory therapy by persons licensed to perform such services; and oxygen and its administration.

Benefits will be provided for Covered Services prescribed by the Member's Physician and considered Medically Necessary and Medically Appropriate.

No Home Health Care benefits will be provided for:

- transportation services;
- services rendered primarily for Custodial Care;
- dietician services;
- social case work or homemaker services;
- home health aide;
- maintenance therapy; or
- food, including home-delivered meals.

Prior Authorization is required before Home Health Care services are rendered. Home Health Care is limited to 45 visits per Calendar Year.

Home Infusion Therapy

Benefits are available for Medically Necessary and Medically Appropriate home infusion therapy. Prior Authorization may be required for certain home infusion therapy medications.

Hospice Care

Hospice Care is an alternative to lengthy inpatient treatment for terminally ill patients. The patient's Physician must establish a plan of treatment. An approved Hospice must provide the services.

In-home services are available, such as:

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

The Deductible and Coinsurance will not apply to expenses incurred for Hospice care. The Coinsurance Percentage will be 100% for this service.

Inpatient Hospice Care is subject to medical review by Care Management.

Hospital Emergency Services

Benefits will be provided subject to Deductible and Coinsurance for Emergency Services received in a Hospital Emergency department when symptoms have been recorded by the attending Physician that an Emergency Medical Condition could exist.

Prior Authorization for Emergency Services will not be required. However, once the Member's medical condition has stabilized, Prior Authorization will be required for continuing inpatient care or transfer to another facility. Benefits will be reduced if such Prior Authorization is not obtained.

Emergency Services received in an Out-of-Network Hospital Emergency department will be covered at the Network Provider Coinsurance Percentage level, after applicable Deductibles have been met, until the Member's Emergency Medical Condition is stabilized. Further treatment of the condition by an Out-of-Network Provider will be subject to the Deductible, Out-of Network Coinsurance and Out-of-Network Out-of-Pocket Maximum.

An “Emergency” or "Emergency Medical Condition" means the sudden onset of a 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 the absence of immediate medical attention, could potentially result in:

- placing the person’s health in serious jeopardy;
- serious impairments to bodily functions;
- serious dysfunction of any bodily organ or part; or
- other serious medical consequences.

An “Emergency” does not include treatment of a Chronic condition in which subacute 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.

“Emergency Services” means 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 a Physician or Hospital protocol.

Hospital Inpatient Services

- Room, board, and general nursing care in a
  - semi-private room,
  - private room (limited to most common semi-private room rate, unless approved by the Plan),
  - special care unit as approved by the Plan;
- Use of operating and treatment rooms;
- Prescription drugs and medicines, including take home prescription drugs;
- Medical supplies, sterile dressings, casts, splints and crutches;
- Anesthetics;
- Diagnostic services (x-ray, laboratory and certain other tests);
- 23-Hour Observation stays; and
- Certain therapy services.

Prior Authorization is required for Hospital admission.

Hospital Outpatient Services

- Treatment of a sudden and serious illness or Accidental Injuries;
- Removal of sutures, anesthetics and their administration, and other surgical services provided by a Hospital employee other than the surgeon or assisting surgeon;
- Prescription drugs, crutches, and medical supplies;
- Pre-Admission Testing;
- Ambulatory surgery; and
- Kidney dialysis clinic.

Inpatient Rehabilitation Facility

An Inpatient Rehabilitation Facility is an inpatient facility which provides multi-disciplinary, structured, intensive therapy. Care is given by or under the supervision of Physicians and is monitored by Care Management.

Prior Authorization is required for this service. Inpatient Rehabilitation services are limited to 28 days per Calendar Year.

Maternity Services

Pregnancy and childbirth are not covered.

Multiple or Bilateral Surgical Procedures

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

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

Occupational Therapy

Occupational therapy is covered only for the treatment of major trauma to the hand. Benefits for Outpatient services are limited to 30 visits per Calendar Year.

Prior Authorization must be obtained prior to services being rendered.

Orthognathic Surgery For Treatment of Clinically Significant Obstructive Sleep Apnea

Benefits are available for orthognathic surgery for the treatment of clinically significant obstructive sleep apnea (OSA) only after all of the following requirements have been met. The Member must have:

- documented results of a full polysomnogram (sleep study) which confirms a diagnosis of obstructive sleep apnea due to type II obstruction (oropharynx/hypopharynx) or type III obstruction (hypopharynx); and
- failed to respond to or tolerate nasal continuous positive airway pressure (nCPAP); and
- been treated unsuccessfully by uvulopalatopharyngoplasty (UPPP), if OSA is due to type I obstruction (oropharynx); and
- been confirmed by fiberoptic pharyngoscopy and cephalometric radiographs with tracing that the site of obstruction is oropharynx (palate) and/or hypopharynx (base of tongue); and
- a pre-surgical physical evaluation supporting the need for orthognathic surgery.

Prior Authorization must be obtained prior to services being rendered. Medical records must be submitted to Us to substantiate the preceding requirements have been met.

Physical Therapy

Benefits are available for Medically Necessary and Medically Appropriate physical therapy services to relieve pain, restore bodily function, and prevent disability following illness, injury, or loss of a body part. Prior Authorization is required for services rendered at home. Outpatient physical therapy is limited to 40 visits per Calendar Year.

Physicians' Services

- Services and supplies for the diagnosis and treatment of illness or injury, including surgery.
- A second and/or third surgical opinion received before surgery.
- Services of an attending Physician for inpatient or outpatient services, or consultation services when requested by the attending Physician.
- Services of a Physician for treatment by x-ray, radium, or other radioactive substances.

Private Duty Nursing

Benefits are available for Medically Necessary and Medically Appropriate private duty nursing in the Member's home.

Prior Authorization must be obtained prior to services being rendered.

Prosthetic Appliances

When approved by the Plan, the cost of prosthetic appliances needed to replace all or part of an absent or malfunctioning body part, including surrounding tissue, is a Covered Service. The Plan also pays benefits to fit, adjust, repair or replace the device, provided the need for this arises from normal wear or the Member's physical development--not as a result of improved technology, loss, or theft to the appliance or device. No benefit will be provided for an artificial heart, lung, liver, pancreas or any other artificial organ or any associated expense(s). This benefit does not include dental appliances or the replacement of cataract lenses.

Prior Authorization must be obtained prior to services being rendered.

Radiation Therapy

Treatment of disease by x-ray, radium, or radioactive isotopes is a Covered Service.

Reconstructive Surgery

Surgery to restore bodily function or correct deformity that began on or after the Effective Date of this Coverage, subject to all terms and conditions of this Contract, is a Covered Service. Benefits are only for problems caused by disease, injury, birth or growth defects, or previous treatments.

Respiratory Therapy

Introduction of dry or moist gases into the lungs is a Covered Service.

Skilled Nursing Facility

Benefits are available for a Skilled Nursing Facility, a facility which mainly provides inpatient skilled nursing and related services to patients requiring convalescent and rehabilitative care. Such care is given by or under the supervision of Physicians. A skilled nursing facility is not, other than incidentally, a place that provides:

- minimal custodial, ambulatory, or part-time care, or
- treatment for mental illness, alcoholism, drug abuse or pulmonary tuberculosis.

Skilled Nursing is limited to 60 days per Calendar Year. Prior Authorization is required for this service.

\Speech Therapy

Speech therapy is covered only for disorders of articulation and swallowing resulting from Acute illness, injury, stroke, autism in children under age 12 or cleft palate. Outpatient speech therapy is limited to 30 visits per Calendar Year.

Prior Authorization must be obtained prior to services being rendered.

TMJ (Temporomandibular Joint Syndrome or Dysfunction)

Benefits are available for the diagnosis and treatment of temporomandibular joint syndrome or dysfunction (TMJ or TMD) and associated pain of the joint between the temporal bones and the mandible. Non-surgical treatment of TMJ includes history exam, office visit, x-rays, diagnostic study casts, medications and appliances to stabilize the jaw joint. Non-surgical treatment of TMJ is limited to $750 per Member per Calendar Year, subject to Deductible and Coinsurance. Surgical treatment of TMJ will be considered as any other illness subject to the terms and conditions of this Contract.

Treatment for correction of underbite, overbite, and misalignment of the teeth (including orthognathic surgery except as appropriate per medical policy), including braces for dental indications, is excluded.

Vision Services

Benefits are available for services and supplies which are Medically Necessary and Medically Appropriate for the diagnosis and treatment of diseases and injuries to the eye. One set of eyeglasses or contact lenses required as a result of intraocular surgery or ocular injury. Covered Services must be performed within 90 days of the surgery or injury. Eligible expenses are subject to the Deductible and Coinsurance specified in the Schedule of Benefits. The maximum benefit payable for this service is $100.

Section IX
Prescription Drug Benefits

PRESCRIPTION DRUGS

Benefits are available for prescription drugs, subject to the Deductible and Coinsurance, for use by a Member outside of a Hospital or Other Facility. In order to be considered covered, such drug must be:

- prescribed by a licensed practitioner who is authorized by law to prescribe a drug on or after the Member's Effective Date of Coverage,
- approved for use by the Food and Drug Administration (FDA) for the prescribed indication,

  (However, 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.)
- dispensed by a licensed Pharmacist, either in person or through home delivery, and
- unavailable for purchase without a prescription.

Some prescription drugs may require Prior Authorization or may be subject to quantity limitations. Please contact the number listed on the Member's Plan ID card for details.

The Pharmacist may not be You or a member of Your or the Member's immediate household.

No benefits are available for prescription drugs purchased outside the United States, unless approved by the Plan.

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 doctor's office are not covered except as otherwise specified in this Contract. However, benefits will be available for:

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

The Member's prescription drug claims are electronically submitted by the pharmacy for reimbursement at the time of service. You or the Member are responsible for the full cost of the Member's prescription drug claims at the time of service and will be reimbursed based on the Maximum Allowable Charge at the applicable Coinsurance Percentage after the Member's 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 filled. To obtain a prescription drug claim form, call the toll free number on the Member's Plan ID Card.

PRESCRIPTION DRUG BENEFIT - NETWORK

The network of pharmacies can offer savings through the preferential pricing. To qualify for the savings, You or the Member must go to a Network Pharmacy to obtain the Member's medication. Failure to use a Network Pharmacy may cost You or the Member more money. You or 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.

PRESCRIPTION DRUG BENEFIT - OUT-OF-NETWORK

When You or the Member use an Out-of-Network Pharmacy, the Member will not receive preferential pricing. You or the Member must pay the pharmacy for the prescription at the time of service. You will be reimbursed at the Out-of-Network Coinsurance Percentage applied to the Maximum Allowable Charge after the Member's Deductible is met.

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

PRESCRIPTION DRUG BENEFIT - SELF-ADMINISTERED SPECIALTY PHARMACY PRODUCTS

Benefits are available for certain Medically Necessary and Medically Appropriate self-administered Specialty Pharmacy Products. There is a distinct network for Specialty Pharmacy Products. The network of specialty pharmacies can offer savings through preferential pricing. The Specialty Pharmacy Network Pharmacy is a part of the Member's Plan's Network, and In-Network Benefits apply. Certain Specialty Pharmacy Products require Prior Authorization. The prescribing Physician should contact the Plan for Prior Authorization.

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

When purchasing a self-administered Specialty Pharmacy Product from an Out-of-Network Pharmacy provider, You will be reimbursed, based on the Maximum Allowable Charge, at the Out-of-Network Coinsurance Percentage after the Deductible is met. This will result in higher out-of-pocket expenses for the Member.

PROVIDER-ADMINISTERED SPECIALTY PHARMACY PRODUCTS

Benefits are available for Medically Necessary and Medically Appropriate provider-administered Specialty Pharmacy Products. This benefit includes administration by a qualified provider. Prior Authorization may be required for certain Provider Administered Specialty Pharmacy Products. The benefit will be based on the status of the provider as a Network or Out-of-Network Provider.

PRESCRIPTION DRUG BENEFIT – 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 prescription 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.

Check to see if the Member's pharmacy is a Network Pharmacy provider each time You or the Member fill a Compound Drug. You may have to pay more if You have a Compound Drug filled at a pharmacy that is not a Network Pharmacy provider.

Benefits will be provided at the Network Coinsurance Percentage after the Member's Deductible has been met. If the Member uses a pharmacy that is not a Network Pharmacy provider, You or the Member will be responsible for the difference between Billed Charges and the Maximum Allowable Charge.

Section X
Transplant Benefits

Subject to Deductible and Coinsurance, benefits are available for Medically Necessary and Medically Appropriate services and supplies provided to a Member when the Member is the recipient of the following 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 transplant procedures, which are not considered Experimental or Investigational and which are Medically Necessary and Medically Appropriate as determined by the Plan.

The Member has access to three levels of benefits: Centers of Excellence, Network Providers, and Out-of-Network Providers. If the Member goes to a Center of Excellence, he or she will have the highest level of benefits.

Transplant services or supplies, including pre-transplant evaluation, that have not received Prior Authorization will not be covered.

1. **Prior Authorization**

   Prior Authorization should be obtained as soon as possible after the Member has been identified as a possible candidate for transplant services. To obtain Prior Authorization, the Member or the Member's Physician must contact the Plan's Transplant Case Management department before pre-transplant evaluation or transplant services are received.

   Transplant Case Management is a mandatory program for those Members seeking Transplant Services.

2. **Covered Services**

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

   a. Services and supplies otherwise covered under this Contract.

   b. Services and supplies for each listed covered transplant procedure are covered upon approval by Transplant Case Management.

   c. For all covered transplant services, travel expenses for the Member's evaluation prior to a covered transplant procedure and to and from the site of a covered transplant procedure by: (1) private car; (2) land, air or sea Ambulance; or (3) public transportation. This includes the travel expenses of the Member and one companion. Travel expenses are covered only when a Center of Excellence is used.

      - Reimbursement for travel by private car is available only if the Member must travel more than 30 miles to and from the Center of Excellence. Reimbursement will be limited to the IRS mileage rate in effect at the time of travel.

      - The Member may be reimbursed for meals and lodging expenses not to exceed $150 per day if the Member and companion must travel more than 30 miles to and from the Center of Excellence.

      - The aggregate limit for travel expenses is $10,000 per covered procedure. For purposes of this section, no additional Maximum Allowable Charges will apply.

d. 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 including: (1) testing 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.

The search process and securing the organ are Covered Services. Complications associated with donor organ procurement are not Covered Services.

3. Explanation of Services

Your benefits will vary based on the network status of the provider from which You obtain services. Transplant services, supplies or Charges will be provided in the following manner:

a. All Transplants. Once the Member has notified Transplant Case Management and received Prior Authorization, he or she may decide to have the transplant performed as follows:

- Centers of Excellence. The Member has the transplant performed at a Center of Excellence. The Member receives the highest level of reimbursement for Covered Services. The Plan will reimburse the Center of Excellence at the benefit level listed in the Schedule of Benefits at the Transplant Maximum Allowable Charge. The Center of Excellence cannot bill the Member for any amount over the Transplant Maximum Allowable Charge for the transplant.
- Network Provider. The Member has the transplant performed by a Network Provider. The Plan will reimburse the Network Provider at the benefit level listed in the Schedule of Benefits, limited to the Transplant Maximum Allowable Charge. There is no maximum to the Member's liability. The provider may bill the Member for any amount not covered by the Plan.
- Out-of-Network. The Member has the transplant performed by an Out-of-Network Provider. The Plan will reimburse the Out-of-Network Provider only at the benefit level listed in the Schedule of Benefits, limited to the Transplant Maximum Allowable Charge. There is no maximum to the Member's liability. The Out-of-Network Provider may bill the Member for any amount not covered by the Plan.

Please contact Transplant Case Management to determine the applicable Transplant Maximum Allowable Charge. The Transplant Maximum Allowable Charge is subject to change.

Transplant Case Management will coordinate all transplant services including pre-transplant evaluation.

4. Exclusions

The following services, supplies and Charges are not covered under this section:

a. Any transplant and related services for which Prior Authorization was not obtained.

b. Services or supplies not specified as Covered Services under this section.

c. Any attempted covered transplant procedure that was not performed, except where such failure of performance is beyond the control of the Member.

d. If the Member received Prior Authorization through Transplant Case Management, but does not obtain services through the Center of Excellence, the Member will have to pay the provider any additional Charges not covered by the Plan.

e. Non-Covered Services, except for those which are Medically Necessary and Medically Appropriate for the treatment of immediate and direct complications of a covered procedure.

f. Services which are covered under any private or public research fund, regardless of whether the Member applied for or received amounts from such fund.

g. Any non-human, artificial, or mechanical organ or any associated expense.

h. 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.

i. Donor services including screening and assessment procedures which have not received Prior Authorization.

j. 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.

k. Harvest, procurement, and storage of stem cells, whether obtained from peripheral blood, cord blood, or bone marrow when re-infusion is not scheduled within 3 months of harvest.

l. Transplants not involving the organs designated under this section except as otherwise specified in this Contract.

m. Any service specifically excluded under the Plan's "Limitations/Exclusions" section, except as otherwise provided in this section.

WHAT YOU CAN DO TO CONTAIN COSTS

Before a Member receives health care services, check to be sure that the health care provider is a member of the Network. You may also obtain the current directory of Network Providers by calling the toll free number on the Member's Plan ID card.

PRIOR AUTHORIZATION

The purpose of Prior Authorization is solely to ensure that patients receive Covered Services at the appropriate time and in the appropriate setting.

Prior Authorization is required for certain Covered Services. The treating Physician must contact the Plan at the telephone number shown on the Member's Plan ID card before Covered Services are provided. Otherwise, benefits may be reduced or denied. Covered Services that require Prior Authorization include:

Advanced Radiological Imaging
Certain Home Infusion Therapy Medications;
Certain Specialty Pharmacy Products;
Certain Retail Prescriptions;
Home Health Care
Inpatient Behavioral Health Care;
Impatient and Outpatient Cardiac Rehabilitative Services;
Inpatient Hospital Stays;
Inpatient Rehabilitation Facility;
Nuclear Cardiology;
Occupational Therapy;
Orthognathic Surgery;
Private Duty Nursing;
Prosthetic Appliances more than $1,000;
Skilled Nursing Facility;
Speech Therapy;
Therapeutic/Rehabilitative Therapy when provided at home;
Transplants.

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.

Be sure to ask the doctor to contact the Plan to obtain Prior Authorization 30 days before admitting a Member to a Hospital.

The Member's doctor must report Emergency admissions to the Plan within 24 hours or within one working day after admission. If the Physician determines that a Member needs to remain in the Hospital for a longer period of time, additional authorization must be requested.

Prior Authorization is not required when Medicare is the primary payor. Prior Authorization will not be required for the following Advanced Radiological Imaging services when performed during an Emergency or during an inpatient Hospital stay: CT Scans, CTA Scans, PET Scans, MRA, MRI, MRS, and Nuclear Cardiology.

You may call customer service to determine whether Prior Authorization is required. If Prior Authorization is required and not obtained, benefits may be reduced to 50% or denied for

Network and Out-of- Network Providers. In some cases, a Network Provider cannot bill You for services that are denied for no Prior Authorization.

Network Providers are responsible for obtaining Prior Authorization for the Member before providing services. It is the Member's responsibility to obtain the Prior Authorization if the provider is an Out-of-Network Provider.

If the reduction to 50% results in liability to the Member that is in excess of $2,500 above what the Member would have paid had Prior Authorization been obtained, the Member may contact customer service to have the claim reviewed and adjusted. In this event, the reduction of the Member's liability will be limited to $2,500.

All organ transplant services require Prior Authorization. Benefits for organ transplant services will be denied if Prior Authorization is not obtained.

Member liability resulting from any reduction in benefits will not apply to the Out-of-Pocket Maximum.

CONCURRENT UTILIZATION REVIEW

The goal of Concurrent Utilization Review is to encourage the appropriate use of hospitalization.

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

CARE MANAGEMENT

The Care Management program will identify Members with potentially complicated medical needs, Chronic illness and/or catastrophic illnesses or injuries that may be suited for alternative treatment plans. After evaluation of the Member's condition, the Plan may determine that alternative treatment is Medically Necessary and Medically Appropriate. In that event, the Plan may elect to offer alternative benefits for services not otherwise specified as Covered Services in this Contract. Such benefits will be offered only in accordance with a plan of treatment with which the Member (or the Member's legal guardian) and the attending Physician concur.

Care Management services will be made available on a case-by-case basis to individual Members. Under no circumstances does the Member acquire a vested interest in continued receipt of a particular benefit or level of benefits. Offer or confirmation of alternative benefits or modes of care in one instance shall not obligate the Plan to provide the same or similar benefits for the Member in another instance. In addition, nothing herein shall be deemed a waiver of the Plan's right to enforce this Coverage in strict accordance with its express terms and conditions.

Section XII
Claims: How and When To File

WHEN TO APPLY FOR BENEFITS

You or the health care provider should file claims as soon as possible after the Member receives Covered Services. If Covered Services are received on a continuous basis, claims should be submitted at least every 30 days.

All claims must be submitted within 12 months of the date of service.

Within 30 days of receipt of a claim, the Plan will provide You with one of the following:

- an Explanation of Benefits. Benefits will be paid directly to providers.
- a notice of denial of a claim.
- a request for additional information.

Claims will be processed based on information available at the time the claim is received. The Plan will not be responsible for over or under payment of claims resulting from incomplete or inaccurate information, provided reasonable efforts are made to obtain and verify relevant facts when claims are submitted.

CLAIMS FOR NETWORK PROVIDER SERVICES

Usually, when a Member receives care, the Network Provider will ask that benefits be assigned to the provider. A Network Provider will file the necessary claims. Available benefits will be paid directly to the provider, and You will receive an Explanation of Benefits (EOB) showing the payment and any balance that is Your responsibility.

CLAIMS FOR OUT-OF-NETWORK PROVIDER SERVICES

If an Out-of-Network Provider asks You to pay for treatment, ask the provider to give You a claim form and an itemized statement listing the services received and the Charges for each service. You may then submit a claim to the Plan, and available benefits will be paid to You. Be sure to include: (1) the patient's name; (2) the Member's Plan identification and group numbers; (3) treatment date(s); (4) the patient's diagnosis; and (5) information about any other health insurance the patient may have.

Benefits for Covered Services are subject to the Deductible, Out-of-Network Coinsurance Percentage and the Out-of-Network Out-of-Pocket Maximum. Charges billed by an Out-of-Network Provider which exceed the Maximum Allowable Charge will be the responsibility of the Member.

CLAIMS FOR NON-CONTRACTED PROVIDER SERVICES

Non-Contracted Providers may or may not file the Member's claims for You. Benefits for Covered Services are subject to the Deductible, Network Coinsurance and Network Out-of-Pocket Maximum. Charges billed by a Non-Contracted Provider which exceed the Maximum Allowable Charge will be the responsibility of the Member.

CLAIMS FOR PRESCRIPTION DRUGS

The Member's prescription drug claims are electronically submitted by the pharmacy for reimbursement at the time of service. You are responsible for the full cost of the Member's prescription drug claims at the time of service and will be reimbursed based on the Maximum Allowable Charge at the applicable Coinsurance Percentage after the Member's 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 filled. To obtain a prescription drug claim form, call the toll free number on the Member's Plan ID Card.

GRIEVANCE PROCEDURE

A. Introduction

The Plan's 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 Your local TRH Representative or the customer service department, at the number listed on the Member's Plan ID card: (1) to file a Claim; (2) if You have any questions about this Plan or other documents that You receive from the Plan (e.g. an explanation of benefits); or (3) to initiate a Grievance concerning a dispute.

1. The Procedure can only resolve disputes that are subject to the Plan's control.
2. 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.
3. 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. In addition, an Adverse Benefit Determination includes any rescission of Coverage or a denial of Coverage in an initial eligibility determination.
    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 Contract will cover that service. 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. The Plan's 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.
4. You may request a form from the Plan to authorize another person to act on Your behalf concerning a dispute.
5. You and the Plan may agree to skip one or more of the steps of this Procedure if it will not help to resolve the dispute.
6. Any dispute will be resolved in accordance with applicable Tennessee or Federal laws and regulations, and this Contract.

B. 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 Representative or a customer service 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 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 The Plan issues notice of an Adverse Benefit Determination 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 an Adverse Benefit Determination is issued, You may give up the right to take any action related to that dispute.

   Contact Your local TRH Representative or the customer service department at the number listed on the Member's 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 the Plan has received and reviewed Your Grievance, the Plan's 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 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 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 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. The Plan will send You a copy of such documentation or information, without Charge, upon written request.

5. Second Level Grievance Procedure

   If You are not satisfied You may file a written request for a second level Grievance within ninety (90) days after the first level Grievance committee's decision has been issued. Upon receipt of Your request for a second level Grievance, Your request along with all submitted information will be forwarded to TRH 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 present testimony to 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 present testimony concerning Your second level Grievance.

   In either case, the second level Grievance committee will meet and consider all relevant information presented about Your second level Grievance and any new, relevant information that You submit for consideration.

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:

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

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

   c. 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.

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

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

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.

BRINGING LEGAL ACTION

Any legal action taken with respect to Coverage under this Plan must begin within 2 years following the period permitted for timely filing of a claim. Legal action may not be taken until:

- A properly completed notice of claim has been submitted, and
- Such claim has either been denied in writing or not followed by a written response within 30 days after it is submitted, and
- The Member has exercised all of his or her review and appeal rights under this Contract, as defined under Grievance Procedure.

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". Rules of this Section determine whether the benefits available under this Contract are determined before or after those of another Plan. In no event, however, will benefits under this Contract be increased because of this provision.

Periodically the We will send You a form to update the Member's COB information. Please complete the form and return it to Us to ensure the Member's records are accurate. Failure to return the Member's COB information to Us shall entitle the Plan to withhold any and all benefits due the Member under the Plan until such 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.

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 and Your Covered Dependents for illnesses or injuries caused by third parties, including the right to recover the reasonable value of prepaid services rendered by Network Providers.

The Plan shall have first lien against any payment, judgment or settlement of any kind that You or Your Covered Dependents 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 or Your Covered Dependents.

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 or Your Covered Dependents 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.

Section XIII
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.

PRE-EXISTING CONDITION WAITING PERIOD

A Member will not be eligible to receive benefits for Pre-Existing Conditions (as defined in Definitions) until the Member has completed a waiting period of at least 12 months beginning with the Effective Date of the Member's Coverage.

Individual Coverage has no maternity benefits.

EXCLUSIONS

1. Services or supplies not prescribed or performed by an Eligible Provider (as defined in the Definitions).
2. Services or supplies which the Plan determines are not Medically Necessary and Medically Appropriate.
3. Services provided before the Member's Coverage begins or after this Coverage is terminated. Services for a Pre-Existing Condition during the Pre-Existing Condition Waiting Period.
4. A drug, device, or medical treatment or procedure which is Investigational (as defined in the Definitions).
5. Any work related illness or injury (unless resulting from self-employment not subject to Workers Compensation insurance requirements).
6. Services or supplies furnished without cost under the laws of any government except Medicaid (TennCare[SM]) coverage provided by the State of Tennessee.
7. Illness or injury resulting from war.
8. Services and supplies for which the Member is not required or legally obligated to pay.
9. Services, supplies or prosthetics for Cosmetic Services. Services, supplies, or prosthetics primarily to change or improve appearance or which are provided in order to correct or repair the results of a prior surgical procedure the primary purpose of which was to change or improve appearance, except as otherwise specified in this Contract.
10. Self-treatment or services provided by any person related to a Member by blood or marriage or any person who resides in the Member's immediate household. A Pharmacist may not be You or a member of Your or the Member's immediate household.
11. Services paid under any other group, blanket or franchise insurance coverage; any other group contract, other health insurance plan, union welfare plan, or labor-management trust plan.
12. Personal, physical fitness, recreational or convenience items and services such as: diapers, disposable underpads, and incontinence pads; barber and beauty services; television; breast pumps; air conditioners; humidifiers; air filters; heaters; physical fitness equipment or programs; recreational equipment; saunas; whirlpools; water purifiers; swimming pools; tanning beds; weight loss programs; home modifications or improvements; motorized vehicles (except Medically Necessary and Medically Appropriate electric wheelchairs).

13. Telephone and e-mail consultations, unless approved by the Plan; Charges incurred due to failure to keep a scheduled appointment; Charges to complete forms or to provide requested medical information or records; writing or calling in a prescription; depositions, testimony or court related fees; handling fees, postage, shipping, mail charges or sales tax; admitting orders unless billed with in-Hospital medical visits or telemedicine except as otherwise specified in this Contract.

14. Hospital admissions which are primarily for diagnostic studies.

15. Whole blood, blood components, and blood derivatives which are not officially classified as drugs.

16. Custodial Care, such as help in walking, getting in or out of bed, or any service that could be performed by non-professional personnel.

17. Routine foot care including, but not limited to, trimming of toe nails, except for diabetic patients. Foot orthotics, shoe inserts and custom made shoes except for diabetic patients or as part of a leg brace.

18. Routine physical examinations and screening examinations, except as otherwise specified in this Contract.

19. Immunizations and vaccinations, including but not limited to, flu shots, flu mist, Human Papilloma Virus (HPV) and shots for traveling outside of the United States, except as otherwise specified in this Contract. Administration Charges for Non-Covered immunizations and vaccinations are not eligible.

20. Services or supplies for dental care, except as otherwise specified in this Contract. Dental services include routine, restorative, prosthetic and orthodontic services.

21. Routine vision screenings. Eyeglasses, contact lenses, and examinations for and the fitting of eyeglasses and contact lenses, except as otherwise specified in this Contract. Eye exercises and/or therapy and visual training.

22. Routine hearing screenings. Hearing aids and examinations for prescribing or fitting of hearing aids, except as otherwise specified in this contract. For the purpose of this limitation/exclusion, "hearing aids" shall include any service, device or surgical procedure designed to restore or enhance the ability to hear, including but not limited to, assistive listening devices, audient bone conductor, electromagnetic, and/or surgically implanted devices (such as cochlear implant).

23. Hospital admissions primarily for physical therapy.

24. Habilitative services of any kind (services to achieve a level of functioning that the Member has never attained). Rehabilitative services including, but not limited to, aquatic therapy, hydrotherapy, educational therapy, occupational therapy, speech therapy, recreational therapy, massage therapy, fluidotherapy, craniosacral therapy, vision exercise therapy, neuromuscular reeducation, cognitive rehabilitation, nutrition therapy, dietary supplements (vitamins), and acupuncture, unless otherwise specified in this Contract.

    (If The Plan determines that services during a continuous Hospital confinement have developed into primarily rehabilitative services, that portion of the stay beginning on the day of such development shall not be covered under this Plan.)

25. Surgery to change sex and related services.

26. Services or supplies that are designed to medically enhance a Member's level of fertility in the absence of a disease state, create a pregnancy, or improve conception quality. Services

include, but are not limited to: artificial insemination; in vitro fertilization; fallopian tube reconstruction; uterine reconstruction; assisted reproductive technology (ART) including, but not limited to, GIFT and ZIFT; fertility injections; fertility drugs; sperm preservation; services for follow up care related to infertility treatments.

However, a service or supply may be covered if it is provided to treat an illness or underlying medical condition resulting in infertility, which include treatment to correct a previous tubal pregnancy and treatment by ovulatory drugs (such as clomid) or hormonal treatment used primarily to treat irregular menstrual periods.

27. Services covered under Medicare, except as required by applicable state or federal law.
28. Non-medical self-care or self-help training and any related diagnostic testing or medical social services.
29. Services, surgeries or supplies to detect or correct refractive errors of the eye.
30. Services or supplies incurred after a Concurrent Review determines the services and supplies are no longer Medically Necessary and Medically Appropriate.
31. Charges in excess of the Maximum Allowable Charge for a service or supply.
32. Services rendered for or in connection with physical therapy which consist primarily in the application, supervision, or direction in the use of exercise or physical fitness equipment--whether or not such services are rendered by an Eligible Provider.
33. Any treatment, service or supply including, but not limited to, surgical procedures for the treatment of obesity or morbid obesity. Any treatment, service or supply arising out of the rendering of, or failure to render, treatment for obesity or morbid obesity.
34. Services or expenses for treatment of illness or injury sustained in the commission of a crime or for treatment while confined in a prison, jail or other penal institution or while in the custody of any government or law enforcement entity.
35. Room, board, and general nursing care rendered on the date of discharge, unless both admission and discharge occur on the same day.
36. A second or third surgical opinion rendered by a Physician in the same medical group or practice as (a) the Physician who initially recommended the surgery, or (b) the Physician who rendered the second surgical opinion.
37. Staff consultations required by Hospital rules.
38. Prosthetic appliances or items of Durable Medical Equipment to replace those which were lost, damaged (self-inflicted), stolen or prescribed as a result of improved technology.
39. Dental appliances, including those used for correction of jaw malformations, except where prescribed as part of a surgical procedure necessary to restore a major bodily function or except as otherwise specified in this Contract.
40. Inpatient private duty nursing in an Acute care Hospital.
41. Over-the-counter drugs (not requiring a prescription), unless required by law or specifically designated as covered under this Plan; prescription devices, dietary supplements, nutritional 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.

42. Replacement of implanted cataract lenses.
43. Court-ordered treatment for a Member unless benefits are otherwise payable.
44. Medical treatment for which a Member has been reimbursed under a mass tort or class action lawsuit, settlement or judgment.
45. Any treatment, services or supplies required as a result of attempted suicide or an intentionally self-inflicted illness or injury whether sane or insane, including any treatment, services or supplies arising out of the rendering of, or failure to render, treatment of any such attempted suicide or self-inflicted illness or injury.
46. Cranial prostheses (Wigs).
47. Services or supplies for sterilization or the reversal of sterilization.
48. Well child services, except as otherwise specified in this Contract.
49. An artificial heart or any other artificial organ, or any associated expense.
50. Treatment of sexual dysfunction, including but not limited to erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido. Treatment includes prescription drugs (such as Viagra, Cialis, etc.) and prosthetic appliances.
51. Services or expenses in connection with a surrogate birth. Surrogate birth means:
    - The union of an egg and sperm then placed in another woman to carry to term; or
    - The insemination of a woman under contract, who carries to term and relinquishes the child to the biological father (and his wife) to parent.
52. Services or supplies for orthognathic surgery, a discipline to specifically treat malocclusion except as appropriate per medical policy and as otherwise specified in the Orthognathic Surgery For Treatment of Clinically Significant Obstructive Sleep Apnea benefit in the Member Benefits section of this Contract. This exclusion supersedes any other provision in this Contract that may be interpreted as offering Coverage for this type of surgery.
53. Orthotripsy (extracorporeal shock wave therapy for musculoskeletal conditions).
54. Speech devices and examinations for prescribing or fitting of speech devices, including but not limited to Dynavox.
55. Marriage counseling, pastoral counseling, conjoint therapy, sex therapy, assertiveness training, hypnosis and regressive hypnotic techniques.
56. Cranial orthosis, including helmet or headband, for the treatment of plagiocephaly.
57. Genetic testing and genetic counseling for preventive services.
58. Services and supplies related to complications of Non-Covered Services.
59. Normal pregnancy and childbirth. Benefits for Complications of Pregnancy are provided on the same basis as any other illness.
60. Nicotine replacement therapy and aids to smoking cessation including, but not limited to, patches or prescription drugs.
61. Prescription drugs intended to terminate a pregnancy including, but not limited to, RU-486.
62. Ambulance Charges for dispatch of an Ambulance that is not used by a Member; Charges for transport to a Physician's office, outpatient department of a Hospital for medical care or the patient's home; or Charges for waiting time and extrication.
63. 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 Provider, 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, Provider 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 Provider 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