BlueCross BlueShield of Tennessee
An Independent Licensee of the BlueCross BlueShield Association

**Group Name:** Resource Label Group, LLC
**Network:** Blue Network S
**Effective Date:** 6/1/2010
**Option Number:** 1

| Plan Benefits | HRA Compatible PPO 2000/ 80% | |
|---|---|---|
| **Benefit Features** | **Network Providers** | **Out-of-Network Providers [2]** |
| **Annual Deductible** | | |
| Individual | $2,000 | $4,000 |
| Family | $4,000 | $8,000 |
| **Annual Out-of-Pocket Maximum Amount** | | |
| Individual | $3,000 | $9,000 |
| Family | $6,000 | $18,000 |
| **Dependent Age Limit** | To age 24 | |
| **Lifetime Maximum Benefit** | $5,000,000 | |
| **Pre-Existing Waiting Period [1]** | 12 months | |
| **4th Quarter Deductible Carryover Provision** | Not Included | |
| **Benefits for Covered Services** | **Network Benefits** | **Out-of-Network Benefits [2]** |
| **Practitioner Office Services** | | |
| Primary Care Office Visits [3] | 80% after Deductible | 60% after Deductible |
| Specialist Office Visits | 80% after Deductible | 60% after Deductible |
| Routine Diagnostic Lab, X-Ray, & Injections | 80% after Deductible | 60% after Deductible |
| Advanced Radiological Imaging [6][13] | 80% after Deductible | 60% after Deductible |
| Provider-Administered Specialty Drugs [11] | $100 Copay | 60% after Deductible |
| **Preventive Health Care Services** | | |
| Well Child Care (to age 6) | 80% after Deductible | 60% after Deductible |
| Annual Well Woman Exam | 80% after Deductible | 60% after Deductible |
| Annual Mammography Screening | 80% after Deductible | 60% after Deductible |
| Annual Cervical Cancer Screening | 80% after Deductible | 60% after Deductible |
| Prostate Cancer Screening | 80% after Deductible | 60% after Deductible |
| Immunizations (to age 6) | 80% after Deductible | 60% after Deductible |
| Well Care Services (ages 6 and up) [14] - $750 annual limit | 80% after Deductible | 60% after Deductible |
| **Services Received at a Facility (includes professional and facility charges)** | | |
| Inpatient Services [4] | 80% after Deductible | 60% after Deductible |
| Outpatient Surgery [5] | 80% after Deductible | 60% after Deductible |
| Routine Diagnostic Services-Outpatient | 80% after Deductible | 60% after Deductible |
| Advanced Radiological Imaging-Outpatient [6][13] | 80% after Deductible | 60% after Deductible |
| Provider-Administered Specialty Drugs [11] | 80% after Deductible | 60% after Deductible |
| Other Outpatient Services [7] | 80% after Deductible | 60% after Deductible |
| Emergency Care Services [9] | 80% after Deductible | 80% after Deductible |
| Emergency Care Advanced Radiological Imaging [6][13] | 80% after Deductible | 80% after Deductible |
| **Medical Equipment** | | |
| Durable Medical Equipment - $2,500 annual limit | 80% after Deductible | 60% after Deductible |
| Prosthetics - $20,000 annual limit | 80% after Deductible | 60% after Deductible |
| Orthotic Appliances | 80% after Deductible | 60% after Deductible |
| **Behavioral Health** | | |
| Inpatient: Unlimited days per calendar year | 80% after deductible | 60% after Deductible |
| Outpatient: Unlimited days per calendar year | 80% after deductible | 60% after Deductible |
| **Therapeutic Services [8]** | | |
| Therapy (Limited to 20-36 visits per therapy type per year) | 80% after Deductible | 60% after Deductible |
| **Skilled Nursing Facility & Rehabilitation Facility Services [4]** | | |
| Limited to 60 days combined | 80% after Deductible | 60% after Deductible |
| **Home Health Services [13]** | | |
| Limited to 60 visits per year | 80% after Deductible | 60% after Deductible |
| **Hospice Services** | 100% | 60% after Deductible |
| **Ambulance Service** | 80% after Deductible | 80% after Deductible |
| **Pharmacy** | | |
| Prescription Drugs[10][12] | $10/$35/$50 - $200 Brand Ded | |
| Specialty Drugs[10][11][12] | Preferred - $100 Copay / Non-Preferred - $200 Copay | |

**Notes:**

1. HIPAA regulations apply. A Group enrollee's pre-existing condition waiting period can be reduced by enrollee's applicable 'creditable coverage'.
2. Out-of-network benefit payment based on BlueCross BlueShield of Tennessee maximum allowable charge. You are responsible for paying any amount exceeding the maximum allowable charge.
3. The lower copay applies to Family Practice, General Practice, Internal Medicine, OB/Gyn, Pediatrics, Nurse Practitioners and Physician Assistants.
4. Services require prior authorization. When using network providers outside Tennessee and all out-of-network providers, benefits will be reduced to 50% if prior authorization is not obtained and services are medically necessary. If services are not medically necessary no benefits will be provided.
5. Surgeries include incisions, excisions, biopsies, injection treatments, fracture treatments, applications of casts and splints, sutures, and invasive diagnostic services (e.g., colonoscopy, sigmoidoscopy and endoscopy).
6. CAT scans, PET Scans, MRIs, nuclear medicine and other similar technologies.
7. Includes services such as chemotherapy, radiation therapy, and renal dialysis.
8. Physical, speech, manipulative, and occupational therapies are limited to 20 visits per therapy type per year. Cardiac and pulmonary rehabilitative therapies are limited to 36 visits per therapy type per year.
9. Copay, if applicable, waived if admitted to hospital.
10. See attached rider for Pharmacy exclusions and Specialty Drug vendors.
11. Refer to www.bcbst.com for Specialty Pharmacy Drug List.
12. Copay per prescription, up to 30 day supply.
13. Requires prior authorization.
14. Services include: annual health assessment, childhood immunizations, blood pressure screening, periodic cholesterol screening, Tetanus-diphtheria (Td) booster, other recommended adult immunizations and immunizations not completed in childhood, immunizations for travel to foreign countries, other prescribed x-ray and lab screenings associated with preventive care, vision and hearing screenings performed by the physician during the preventive health.

## Exclusions From Coverage

- Services or supplies not listed as Covered Services in the Evidence of Coverage (EOC);
- Services or supplies that are not Medically Necessary and Appropriate;
- Services or supplies that are Investigational;
- Illness or injury resulting from war, that occurred before Your Coverage began under this EOC and that is Covered by veteran's benefit or other coverage for which You are legally entitled;
- Self treatment or training;
- Staff consultations required by hospital or other facility rules;
- Services that are free;
- Treatment of work related illness or injury;
- Personal, physical fitness, recreational or convenience items and services, even if ordered by a Practitioner;
- Services or supplies, including those related to a Hospital Confinement, received before Your effective date for Coverage with this Plan;
- Services or supplies received after Your Coverage under this Plan ceases for any reason, even though the expenses relate to a condition that began while You were Covered;
- Services or supplies received in a dental or medical department maintained by or on behalf of the employer, mutual benefit association, labor union or similar group;
- Services or charges to complete a claim form or to provide medical records or other administrative functions;
- Telephone consultations, e-mail or web based consultations, or telemedicine services, or charges for failure to keep a scheduled appointment;
- Court ordered examinations and treatment, unless Medically Necessary;
- Room, board and general nursing care rendered on the date of discharge, unless admission and discharge occur on the same day;
- Benefits for Pre-existing Conditions are excluded until any Pre-existing Condition Waiting Periods have been met;
- Charges in excess of the Maximum Allowable Charge for Covered Services or any charges which exceed the Lifetime Maximum;
- Any service stated in the EOC as a non-Covered Service or limitation;
- Charges for services performed by You or Your spouse, or Your or Your spouse's parent, sister, brother or child;
- Any charges for handling fees;
- Nicotine replacement therapy and aids to smoking cessation including, but not limited to, patches;
- Safety items, or items to affect performance primarily in sports-related activities;
- Services or supplies, including bariatric surgery, for weight loss or to treat obesity, even if You have other health conditions that might be helped by weight loss or reduction of obesity;
- Any re-operation or surgery related to bariatric surgery, including, but not limited to, complications of bariatric surgery or body remodeling following weight loss;
- Services or supplies related to treatment of complications (except Complications of Pregnancy) that are a direct or closely related result of a Member's refusal to accept treatment, medicines, or a course of treatment that a Provider has recommended or has been determined to be Medically Necessary, including leaving an inpatient medical facility against the advice of the treating physician;
- Cosmetic services;
- Blepharoplasty and browplasty, except for: correction of injury to the orbital area resulting from physical trauma or non-cosmetic Surgical Procedures (e.g., removal of malignancies); treatment of edema and irritation resulting from Graves' disease; or correction of trichiasis, ectropion, or entropion of the eyelids;
- Services and charges related to the care of the biological mother of an adopted child, if the biological mother is not a Member. Services and charges relating to surrogate parenting;
- Sperm preservation;
- Orthognathic Surgery;
- Maintenance Care;
- Private duty nursing;
- Pharmacogenetic testing or pharmacogenomics;
- Treatment of sexual dysfunction, regardless of cause;
- Services or supplies related to complications of cosmetic procedures, complications of bariatric surgery, re-operation of bariatric surgery or body remodeling following weight loss;
- Methadone maintenance therapy and buprenorphine maintenance therapy;
- Cranial orthosis, including helmet or headband, for the treatment of plagiocephaly;
- Chelation therapy, except for control of ventricular arrhythmias or heart block associated with digitalis toxicity; Emergency treatment of hypercalcemia; extreme conditions of metal toxicity, including thalassemia with hemosiderosis; Wilson's disease (hepatolenticular degeneration); and lead poisoning;
- Vagus nerve stimulation for the treatment of depression;
- Artificial intervertebral disc;
- Balloon sinuplasty for treatment of chronic sinusitis;
- Treatment for benign gynecomastia;
- Treatment for hyperhidrosis;
- Percutaneous intradiscal eletrothermal annuloplasty and percutaneous intradiscal radiofrenecy thermocoagulation to treat chronic discogenic back pain;
- Office visits, physical exams and related immunizations and tests, when required solely for: sports; camp; employment; travel; insurance; marriage or legal proceedings;
- Routine foot care for the treatment of: flat feet; corns; bunions; calluses; toenails; fallen arches; and weak feet or chronic foot strain;
- Foot orthotics, shoe inserts and custom made shoes, except as required by law for diabetic patients or as a part of a leg brace;
- Dental procedures, except as otherwise indicated in the EOC;
- Inpatient stays primarily for therapy (such as physical or occupational therapy);
- Private room when not Authorized by the Plan and room and board charges are in excess of semi-private room;
- Emergency treatment of a chronic, non-Emergency condition, where the symptoms have existed over a period of time, and a prudent layperson who possesses an average knowledge of health and medicine would not believe it to be an Emergency;
- Ambulance transportation for Your convenience, that is not essential to reduce the probability of harm to You, or when You are not transported to a facility;
- Behavioral Health Services except as specified in separate Rider;
- Services or supplies that are designed to create a pregnancy, enhance fertility or improve conception quality;
- Reversals of sterilizations;
- Induced abortion unless: the health care Practitioner certifies in writing that the pregnancy would endanger the life of the mother; the pregnancy is a result of rape or incest; the fetus is not viable; or the fetus has been diagnosed with a lethal or otherwise significant abnormality;
- Services, supplies or prosthetics primarily to improve appearance;
- Surgeries to correct or repair the results of a prior Surgical Procedure, the primary purpose of which was to improve appearance, even if that prior procedure was a Covered Service;
- Surgeries and related services to change gender (transsexual Surgery);
- Custodial, domiciliary or private duty nursing services;
- Cognitive rehabilitation;
- Therapy/Rehabilitative treatment beyond what can reasonably be expected to significantly improve health, including therapeutic treatments for ongoing maintenance or palliative care;
- Enhancement therapy that is designed to improve Your physical status beyond Your pre-injury or pre-illness state;
- Complementary and alternative therapeutic services, including, but not limited to: massage therapy; acupuncture; craniosacral therapy; cognitive rehabilitation; vision exercise therapy; and neuromuscular reeducation;
- Therapy modalities that do not require the attendance or supervision of a licensed therapist;
- Behavioral therapy, play therapy, communication therapy, and therapy for self correcting language dysfunctions as part of speech therapy, physical therapy or occupational therapy programs;
- Organ transplant and related services that were not Authorized through Transplant Case Management;
- Transplant related charges in excess of the Transplant Maximum Allowable Charge;
- Donor services including screening and assessment procedures that have not received Prior Authorization;
- Removal of an organ from a Member for purposes of transplantation into another person, except as Covered by the Donor Organ Procurement provision;
- Routine dental care and related services;
- Treatment for correction of underbite, overbite, and misalignment of the teeth;
- Extraction of impacted teeth, including wisdom teeth;
- Diagnostic services that are not Medically Necessary and Appropriate;
- Diagnostic services not ordered by a Practitioner;
- Pharmaceuticals purchased with a prescription except those dispensed at a participating facility, unless listed in a separate rider;
- Pharmaceuticals that may be purchased without a prescription;
- Self-administered Specialty Drugs as identified on the Plan's Specialty Drug list, except as may be Covered by a separate Rider;
- FDA-approved drugs used for purposes other than those approved by the FDA, unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia;
- Services, surgeries and supplies to detect or correct refractive errors of the eyes;
- Eyeglasses, contact lenses and examinations for the fitting of eyeglasses and contact lenses;
- Eye exercises and/or therapy;
- Visual training;
- Charges exceeding the total cost of the Maximum Allowable Charge to purchase Durable Medical Equipment;
- Unnecessary repair, adjustment or replacement or duplicates of any such equipment;
- Supplies and accessories that are not necessary for the effective functioning of the Covered equipment;
- Items to replace those that were lost, damaged, stolen or prescribed as a result of new technology;
- Items that require or are dependent on alteration of home, workplace or transportation vehicle;
- Motorized scooters, exercise equipment, hot tubs, pool, saunas;
- "Deluxe" or "enhanced" equipment;
- Computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, and seat lifts of any kind;
- Patient lifts, auto tilt chairs, air fluidized beds, or air flotation beds, unless approved by Case Management for a Member who is in Case Management;
- Diabetic treatments or supplies that are not prescribed and certified by a Practitioner as being Medically Necessary;
- Diabetic supplies not required by state statute;
- Hearing aids;
- Prosthetics primarily for cosmetic purposes, including but not limited to wigs, or other hair prosthesis or transplants;
- Replacements of contacts after the initial pair have been provided following cataract surgery;
- Items such as non-treatment services or: routine transportation; homemaker or housekeeping services; behavioral counseling; supportive environmental equipment; Maintenance Care or Custodial Care; social casework; meal delivery; personal hygiene; and convenience items;
- Services such as: homemaker or housekeeping services; meals; convenience or comfort items not related to the illness; supportive environmental equipment; private duty nursing; routine transportation; and funeral or financial counseling;
- Supplies that can be obtained without a prescription (except for diabetic supplies).

Please refer to the Evidence of Coverage for Complete description of benefits and exclusions.

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# Vision Care 2

With these benefits, you may visit any vision care provider for a routine eye exam once a year.

Because some vision providers will not file your claim, be prepared to pay in full, up front. After you file your claim, BlueCross BlueShield of Tennessee will reimburse you for the covered amount, minus your copayment , up to the maximum allowable charge. If the provider charges more than the maximum allowable charge for glasses or contacts, you will pay the excess. You will not pay more than $20 for the vision exam.

### Vision Benefits

| | |
|---|---|
| 1 vision exam per calendar year | $20 Copay |
| 1 set of lenses (including bifocal, trifocal) per calendar year | 100% up to $85 |
| 1 set of contact lenses in lieu of glasses per calendar year | 100% up to $150 |
| 1 set of frames every 2 calendar years | 100% up to $75 |

### Exclusions:

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

- Charges for vision testing exams, lenses, frames or contacts ordered while insured but not delivered within 60 days after coverage is terminated
- Charges for sunglasses, photosensitive, anti-reflective or other optional charges when the charge exceeds the amount allowed for regular lenses
- Charges filed for procedures the Plan determines to be special or unusual, such as orthoptics, vision training, subnormal vision aids, aniseikonis lenses, tonography, etc.
- Charges for lenses that do not meet the Z80.1 or Z80.2 standards of the American National Standards Institute
- Charges in excess of the maximum allowable charge as established by the Plan for frames, lenses and contacts.

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## Extended Well Care

To maintain your health throughout your life, you should receive the proper tests and immunizations at the appropriate time and frequency. Many factors, including your age, gender, family history, and other special needs, determine when particular services are beneficial. Therefore you should discuss with your physician what is right for you.

**You and each eligible dependent age 6 and older may receive preventive health services, not to exceed $750, per calendar year*.** All services must be medically necessary and appropriate and recommended by the U.S. Preventive Health Task Force, or in conjunction with the plan's preventive health care guidelines.

All well care benefits listed are subject to the terms, conditions, limitations, and exclusions contained in the Group Master Contract and the Evidence of Coverage. **All services covered by the Wellcare Rider are subject to normal contract benefits, which are determined by type of service and place of service. ***

The following is a list of items that are covered as a part of the annual preventive health exam for persons age 6 and older:

- Annual Health Assessment
- Childhood immunizations
- Blood pressure screening
- Periodic cholesterol screening
- Periodic colorectal cancer screening, not subject to the $750 calendar year limit*
- Tetanus-diphtheria (Td) booster
- Pneumoccocal immunization
- Other recommended adult immunizations and immunizations not completed in childhood
- Immunizations for travel to foreign countries
- Other prescribed x-ray and lab screenings associated with preventive care
- Vision and hearing screenings performed by the physician during the preventive health exam

Most of these services are not needed every year, or may be appropriate only for people of particular age groups, genders, or those who meet other specific health criteria.

***Important Note Regarding Colonoscopy and Sigmoidoscopy Benefits:**
All services covered by the Well Care Rider are subject to normal contract benefits, which are determined by type of service and place of service. When Well Care Rider services are provided in a physician's office, as the majority are, the office visit benefit applies. However, colonoscopy and sigmoidoscopy are invasive diagnostic surgical procedures, so surgery benefits apply to these services. **Sigmoidoscopies and colonoscopies performed in the physician's office are subject to the office surgery benefit** (copay or deductible/coinsurance, depending on the benefit plan). **Sigmoidoscopies and colonoscopies performed in an outpatient facility are subject to the outpatient surgery benefit** (usually deductible/coinsurance).

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# Behavioral Health Benefits
# Mental Health/Substance Abuse Treatment

### Benefits

| | In-Network | Out-of-Network |
|---|---|---|
| Inpatient Services | 80% after Deductible | 60% after Deductible |
| Outpatient Services | 80% after Deductible | 60% after Deductible |

### Prior Authorization Requirements

Prior Authorization is required for:

- All inpatient levels of care. Inpatient levels of care include Acute care, residential care, partial hospital care, and intensive outpatient programs.
- Electro-convulsive therapy (ECT) provided on an inpatient or outpatient basis.
- Detoxification from narcotic pain medications provided on an inpatient or outpatient basis.
- Outpatient professional visits beginning with the 9th visit. Outpatient visits 1-8 do not require Prior Authorization.

***When an out-of-network provider is used and prior authorization is not obtained and the service is determined to be medically necessary, benefits will be provided at 50% of the maximum allowable charge after the deductible. Benefits will not be provided if the services are determined to be not medically necessary.***

### Mental Health Medication Management Benefit

Outpatient behavioral health visits for the purpose of Medication Management do not count toward the number of mental health outpatient visits per year. Medication Management includes prescription, use, and review of medication.

### Emergency Care

In an emergency, go to the nearest network facility or to the emergency room of the closest medical hospital. An emergency admission to the hospital does not need prior authorization, but you or the hospital must call Behavioral Health Services within 24 hours.

### Access To Services

If you or a covered family member needs help, call the Behavioral Health Services Help Line phone number listed on the back of your BlueCross Blue Shield of Tennessee ID card. **This toll-free number offers assistance 24 hours a day, seven days a week, 365 days a year.**

For inpatient referral and inpatient or outpatient prior authorization please call the telephone number on the back of your ID card and a care manager will direct you to a participating provider. Consult your directory to determine whether a particular provider is in the network. If you choose to use providers who are not in the behavioral health network, your benefits may be reduced. Behavioral health providers include experienced professionals, programs, and facilities to meet your needs. Any information you provide will be confidential.

If you are outside the State of Tennessee and need behavioral health care you must:

- For Inpatient care, have the hospital call Behavioral Health Services within 24 hours.
- For Outpatient care, beginning with the 9th visit, call Behavioral Health Services to request Prior Authorization.
- To determine network status of a provider in the state in which you wish to seek care, call the Behavioral Health Services number on the back of your ID card and ask to speak with a BlueCross BlueShield of Tennessee customer service representative. This call should be made between the hours of 8:30 a.m. and 5:30 p.m. EST, Monday through Friday.

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# $10/$35/$50 Prescription Drug Plan after $200 Brand-only Drug Deductible
# $20/$70/$100 Specialty Drug Plan

**This plan has a "Brand-only" deductible. This means each calendar year you are responsible for the first $200 of Brand Name Drugs before you can start purchasing your prescriptions at the Brand copay below.** Calendar year means the period of time which begins on any January 1st and ends on the following December 31st. When you first become covered by the policy, the first year begins for you on the effective date of your insurance and ends on the following December 31st. The "Brand-only" deductible is separate and will not apply toward satisfying any other deductible or out-of-pocket. The "Brand-only" deductible does not carry forward nor does any prior deductible credit apply to the "Brand-only" deductible. For generic drugs, you pay only the copay shown below and you do not have a deductible. Benefits are available for covered prescription drugs when filled by a BlueCross BlueShield of Tennessee participating pharmacy at the copay below.

| | |
|---|---|
| **Generic Drugs** | **$10 Copay** per prescription, up to 30 day supply |
| **Preferred Brand Name Drugs** | **$35 Copay** per prescription, up to 30 day supply after Brand-only deductible |
| **Non-preferred Brand Name Drugs** | **$50 Copay** per prescription, up to 30 day supply after Brand-only deductible |

## Generic Drugs- your copay is $10

Generic drugs offer the best value. A generic drug is a safe and effective alternative to a brand name drug. You pay the lowest copay when you choose a generic drug. When your doctor writes your prescription, ask about using a generic drug.

Generic drugs are made with the same active ingredients and produce the same effects in the body as their brand-name equivalents. The difference? Just the name and price -- and generics cost less. BlueCross BlueShield of Tennessee encourages the use of generic drugs by offering lower copayments when choosing generics.

## Preferred Brand Drugs- your copay is $35

The Preferred Drug List is a list of therapeutically sound, cost-effective drugs, and is provided to encourage the use of certain drugs within a therapeutic class. When your doctor prescribes a preferred brand drug, your copay is $35 after meeting the $200 Brand Name Drug Deductible. But if you receive a brand-name drug when a generic equivalent is available, you must pay the generic copay plus the cost difference between the brand-name drug and generic drug.

## Non-Preferred Brand Drugs- your copay is $50

When your doctor prescribes a brand drug that is not on the Preferred Drug list, you pay the highest copay of $50 after meeting a $200 Brand Name Drug Deductible. But if you receive a brand-name drug when a generic equivalent is available, you must pay the generic copay plus the cost difference between the brand-name drug and generic drug.

## Pricing at Participating Pharmacies

When a member receives a prescription at a pharmacy, he or she typically pays the appropriate copayment (either generic or brand under a two-tier plan; or generic, preferred brand or non-preferred brand under a three-tier plan). Members pay less than the copayment if the pharmacy's usual price for the drug is less than the copayment.

## Choosing a Brand when a Generic Equivalent is Available

You'll always save money when using generics. In fact, all you pay is the generic copay. But if you request a brand-name drug when a generic equivalent is available, you must pay the generic copay plus the cost difference between the brand-name drug and generic drug after meeting a $200 Brand Name Drug Deductible.

**Limitations**

**These limitations apply to each prescription order.**

Benefits will be provided for

- up to a 30-calendar-day supply of prescription drugs, and/or
- up to a 90-calendar-day supply of prescription drugs obtained through Prescription Home Delivery or the Home Delivery Retail Network.

Some drugs require prior authorization, step therapy, or have quantity limitations. Please refer to the special drug lists on the pharmacy page on www.bcbst.com for more information.

**Step Therapy**

Step Therapy is a form of Prior Authorization. When Step Therapy is required, You must initially try a drug that has been proven effective for most people with Your condition. This initial drug will be a Covered Generic Drug (if available) or a Preferred Brand Drug. However, if you have already tried an alternate, less expensive drug and it did not work, or if Your doctor believes that You must take the more expensive drug because of Your medical condition, Your doctor can contact the Plan to request an exception. If the request is approved, the Plan will cover the requested drug.

**Refills**

Refills must be dispensed pursuant to a Prescription. If the number of refills is not specified in the Prescription, benefits for refills will not be provided beyond one year from the date of the original prescription.

The Plan has time limits on how soon a Prescription can be refilled. If you request a refill too soon, the Network Pharmacy will advise you when your Prescription benefit will cover the refill.

**Prescription Home Delivery**

Enjoy the convenience of prescription home delivery. Simply mail a completed form along with the written prescription and payment in one of the envelopes provided or visit the pharmacy section at www.bcbst.com for other helpful ways to have your prescriptions delivered to your home or another preferred address.

**Home Delivery Retail Network**

Another convenient way to obtain up to a 90-calendar-day supply of drugs is through the Home Delivery Retail Network. The Home Delivery Network is a network of retail pharmacies that are permitted to dispense prescription drugs to BlueCross BlueShield of Tennessee members on the same terms as pharmacies in the Home Delivery Network. A directory of the participating Home Delivery Retail Network is available online at www.bcbst.com.

**Out-of-Network Pharmacies**

If a prescription is filled at an out-of-network pharmacy, you must pay all costs. A claim can then be submitted to BlueCross BlueShield of Tennessee. Reimbursement is based on the BlueCross BlueShield of Tennessee allowed charge, less any applicable copay, deductible or coinsurance amount.

**A Broad Network of Retail Pharmacies**

BlueCross BlueShield of Tennessee members access the Caremark network for retail pharmacy benefits. Your pharmacy network provides tremendous accessibility in Tennessee as well as nationally. A directory of participating pharmacies is available online at www.bcbst.com. Click on Find a Pharmacy, and enter the pharmacy network code that appears in the bottom center of your BlueCross BlueShield of Tennessee ID card. This code will start with RX (RX04, for example).

**Self-Administered Specialty Pharmacy Network and Coverage**

You have a separate network for Specialty Drugs: the Specialty Pharmacy Network. You receive the highest level of benefits when you use a Specialty Pharmacy Network provider for your self-administered Specialty Drugs. **Accredo Health Group**, **Caremark Specialty Pharmacy Services**, and **CuraScript Pharmacy** are experienced in managing high-cost drugs and providing patient support for complex conditions such as Hepatitis C, Multiple Sclerosis, Arthritis and Hemophilia.

| Accredo Health Group | Caremark Specialty Pharmacy Services | CuraScript Pharmacy |
|---|---|---|
| 1-888-239-0725 *(phone)* | 1-800-237-2767 *(phone)* | 1-888-773-7376 *(phone)* |
| 1-866-387-1003 *(fax)* | 1-800-323-2445 *(fax)* | 1-888-773-7386 *(fax)* |

You may purchase self-administered Specialty Drugs from a retail pharmacy, but your copay will be higher. When purchasing self-administered Specialty Drugs from an Out-of-Network Pharmacy, you must pay all expenses and file a claim for reimbursement with us. You will be reimbursed based on the Maximum Allowable Charge, less any applicable Drug Copayment amount.

Please refer to the Specialty Drug List to see which drugs are covered as self-administered Specialty Drugs. Go to www.bcbst.com/Pharmacy.

Specialty Drugs are limited to a **30-day supply** per Prescription.

| | **Specialty Pharmacy Network** | **Other Network Pharmacies** | **Out-of-Network Pharmacies** |
|---|---|---|---|
| A Self-Administered Specialty Drug, as indicated on Our Specialty Drug list. | $100 Drug Copayment per Prescription (not subject to Brand Deductible) | $200 Drug Copayment per Prescription (not subject to Brand Deductible) | You pay all costs, then file a claim for reimbursement. You will be reimbursed based on the Maximum Allowable Charge, less any applicable Drug Copayment amount. (not subject to Brand Deductible) |
| If a drug that is on Our Specialty Drugs list is also a Generic Drug or a Preferred Brand Drug, then Your Copayment will be: | | | |
| A Generic Drug that is also a Self-Administered Specialty Drug, as indicated on Our Specialty Drug list. | $20 Drug Copayment per Prescription (not subject to Brand Deductible) | $40 Drug Copayment per Prescription (not subject to Brand Deductible) | You pay all costs, then file a claim for reimbursement. You will be reimbursed based on the Maximum Allowable Charge, less any applicable Drug Copayment amount. (not subject to Brand Deductible) |
| A Preferred Brand Drug that is also a Self-Administered Specialty Drug, as indicated on Our Specialty Drug list. | $70 Drug Copayment per Prescription (not subject to Brand Deductible) | $140 Drug Copayment per Prescription (not subject to Brand Deductible) | You pay all costs, then file a claim for reimbursement. You will be reimbursed based on the Maximum Allowable Charge, less any applicable Drug Copayment amount. (not subject to Brand Deductible) |

(Please refer to Your EOC for information on benefits for provider-administered Specialty Drugs, which are covered as a Medical benefit.)

**Need More Information?**

For more information on prescription drug coverage or our pharmacy programs call 1-800-565-9140. You can also visit the pharmacy section at www.bcbst.com.

***Benefits will not be provided for:***

- drugs for the treatment of onychomycosis (e.g., nail fungus), except for: 1) diabetics; or 2) immuno-compromised patients.
- growth hormones, except for: 1) treatment of absolute growth hormone deficiency in children whose epiphyses have not closed; 2) patients with "Turner" syndrome; and 3) patients with Prader-Willi syndrome confirmed by appropriate genetic testing;
- prescription and non-prescription medical supplies, devices and appliances, except for syringes used in conjunction with injectable medications or other supplies used in the treatment of diabetes and/or asthma;
- immunizations or immunological agents, including but not limited to: 1) biological sera, 2) blood, 3) blood plasma; or 4) other blood products are not Covered, except for blood products required by hemophiliacs.
- injectable drugs, unless: 1) intended for self -administration; or 2) defined by the Plan.
- drugs which are prescribed, dispensed or intended for use while You are confined in a hospital, skilled nursing facility or similar facility, except as otherwise Covered in the EOC;
- any drugs, medications, Prescription devices or vitamins, available over-the-counter that do not require a Prescription by Federal or State law; except as otherwise Covered in the EOC;
- any quantity of Prescription Drugs which exceeds that specified by the Plan's P & T Committee;
- any Prescription Drug purchased outside the United States, except those authorized by Us;
- any Prescription dispensed by or through a non-retail internet Pharmacy;
- contraceptives which require administration or insertion by a Provider (e.g., non-drug devices, implantable products such as Norplant, except injectables), except as otherwise Covered in the EOC;
- medications intended to terminate a pregnancy (e.g., RU-486);
- non-medical supplies or substances, including support garments, regardless of their intended use;
- artificial appliances;
- allergen extracts;
- any drugs or medicines dispensed more than one year following the date of the Prescription;
- Prescription Drugs You are entitled to receive without charge in accordance with any worker's compensation laws or any municipal, state, or federal program;
- replacement Prescriptions resulting from lost, spilled, stolen, or misplaced medications (except as required by applicable law);
- drugs dispensed by a Provider other than a Pharmacy;
- administration or injection of any drugs;
- Prescription Drugs used for the treatment of infertility;
- Prescription Drugs not on the Drug Formulary;
- anorectics (any drug or medicine for the purpose of weight loss and appetite suppression);
- nicotine replacement therapy and aids to smoking cessation including, but not limited to, patches;
- all newly FDA approved drugs prior to review by the Plan's P & T Committee. Prescription Drugs that represent an advance over available therapy according to the P & T Committee will be reviewed within at least six (6) months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug, will be reviewed within at least twelve (12) months after FDA approval;
- any Prescription Drugs or medications used for the treatment of sexual dysfunction, including but not limited to erectile dysfunction (e.g. Viagra), delayed ejaculation, anorgasmia and decreased libido;
- Prescription Drugs used for cosmetic purposes including, but not limited to: 1) drugs used to reduce wrinkles (e.g. Renova); 2) drugs to promote hair-growth; 3) drugs used to control perspiration; 4) drugs to remove hair (e.g. Vaniqa); and 5) fade cream products;
- any Prescription Drug for which there is an over-the-counter (OTC) equivalent in both dosage and strength, except for insulin;
- FDA approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia;
- Compound drugs filled or refilled at an Out-of-Network Pharmacy;
- drugs used to enhance athletic performance;
- Experimental and/or Investigational Drugs;
- Provider-administered Specialty Drugs, as indicated on Our Specialty Drug list; and
- Prescription Drugs or refills dispensed:
    - in quantities in excess of amounts specified in the BENEFIT PAYMENT section;

- without Our Prior Authorization when required; or
- which exceed any applicable Annual Maximum Benefit, or any other maximum benefit amounts stated in this Rider or the EOC

These exclusions only apply to this Rider. Items that are excluded under the Rider may be Covered as medical supplies under the EOC. Please review your EOC carefully.

Updated: 2008