EVIDENCE OF COVERAGE

ATTACHMENT C: PPO SCHEDULE OF BENEFITS

Group Name: Holston Conference of the United Methodist Church
Group Number: 88662
Annual Benefit Period: January 1, 2020, to December 31, 2020

Network: As shown on Your ID card

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

Covered Services	Network Providers	Out-of-Network Providers [1]
Practitioner Services (physician, specialist or nurse practitioner)		
Office Services Primary Care Practitioner types (Internal Medicine, General Practice, Family Medicine, Pediatrics, Obstetrics & Gynecology, Physician Assistant, Nurse Practitioner, Health Department)	$30 Copayment per visit	60% of the Maximum Allowable Charge after Deductible
All other Practitioners The Copayment for a Physician Assistant or Nurse Practitioner may be based on the Provider type of the delegate physician.	$60 Copayment per visit	60% of the Maximum Allowable Charge after Deductible
Maternity Services	$30 Copayment per visit	60% of the Maximum Allowable Charge after Deductible
Routine diagnostic services	100%	60% of the Maximum Allowable Charge after Deductible
Injections (*including allergy serum*)	100%	60% of the Maximum Allowable Charge after Deductible
Allergy Testing	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Facility Services		
Inpatient Hospital and Behavioral Health Services [2]	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Outpatient Surgery [3]	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Skilled Nursing/Rehab [2] *(limited to 100 days per Annual Benefit Period)*	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Emergency Care Services (Whether the Practitioner is considered an Emergency physician and therefore reimbursable under this benefit is determined by the place of service on the claim.)	80% after Deductible	80% of the Maximum Allowable Charge after Deductible
Advanced Radiological Imaging Services [4]	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Other Services		
Urgent Care Center changes	$30 Copayment per visit	60% of the Maximum Allowable Charge after Deductible
Ground Ambulance	80% after Deductible	80% of the Maximum Allowable Charge after Deductible
Air Ambulance	80% after Deductible	80% of the Billed Charges after Deductible
Durable Medical Equipment	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Prosthetics & Orthotics	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Home health services [6] *(Unlimited visits per year)*	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Hospice	100%	60% of the Maximum Allowable Charge after Deductible
Therapeutic Services [5] *(limited to 60 visits per therapy type per year)*	80% after Deductible	60% of the Maximum Allowable Charge after Deductible
Chiropractic Care *(limited to 30 visits per year)*	$50 Copayment per visit	60% of the Maximum Allowable Charge after Deductible

Covered Services	Network Providers		Out-of-Network Providers [1]
Hearing Aids for Members under age 18 Limited to one per ear every 3 years (as determined by Your Annual Benefit Period)	80% after Deductible		60% of the Maximum Allowable Charge after Deductible
Evaluation and testing of infertility	80% after Deductible		60% of the Maximum Allowable Charge after Deductible
PhysicianNow consultations via telephone, tablet or computer See the "Health and Wellness" section of this EOC for more information	$15 Copayment per consultation		Not Covered
Medical Vision Care			
Vision exam for the treatment of injuries and diseases of the eye – in a Facility	80% after Deductible		60% of the Maximum Allowable Charge after Deductible
Vision exam for the treatment of injuries and diseases of the eye – in a Practitioner's office	**Primary Care Practitioners:** $30 Copayment per visit **Specialists:** $60 Copayment per visit		60% of the Maximum Allowable Charge after Deductible
Frames, lenses, and contacts Covered following treatment and surgery to repair certain injuries and diseases that impair vision	80% after Deductible		60% of the Maximum Allowable Charge after Deductible
Organ Transplant Services			
All Transplant Services, except kidney transplants [7]	**Blue Distinction Centers for Transplants (BDCT) Network:** 80% after Network Deductible, Network Out-of-Pocket Maximum applies.	**Transplant Network: [8]** 80% after Network Deductible, Network Out-of-Pocket Maximum applies.	**Out-of-Network Providers:** 60% of the Maximum Allowable Charge after Out-of-Network Deductible, Out-of-Network Out-of-Pocket Maximum applies.
Kidney Transplant Services [7]	**Network Providers:** 80% after Network Deductible; Network Out-of-Pocket Maximum applies.		**Out-of-Network Providers**: 60% of Maximum Allowable Charge (MAC), after Out-of-Network Deductible, Out-of-Network Out-of-Pocket Maximum applies, amounts over MAC do not apply to the Out-of-Pocket and are not Covered.

Schedule of Pharmacy Prescription Drug Copayments

Prescription Drugs for Retail Network and Home Delivery Network			
	One month supply (Up to 30 days)	Two months' supply (31 to 60 days)	Three months' supply (61 to 90 days)
	Generic Drug/Preferred Brand Drug/Non-Preferred Brand Drug		
RX04 retail network	$25/$40/$75	N/A	N/A
Home Delivery Network	$25/$40/$75	$50/$80/$150	$50/$80/$150
Plus90 Network	$25/$40/$75	$50/$80/$150	$50/$80/$150
Out-of-Network	60% after Plan Deductible		

Self-administered Specialty Drugs - You have a distinct network for self-administered Specialty Drugs: the Preferred Specialty Pharmacy Network. To receive benefits for self-administered Specialty Drugs, You must use a Preferred Specialty Pharmacy Network Provider. For more information on benefits for Provider-administered Specialty Drugs, please refer to the "Specialty Drugs" section of this EOC. **Limited up to a 30-day supply per Prescription**	
	Generic Drug/Preferred Brand Drug/Non-Preferred Brand Drug
Specialty Pharmacy Network –Preferred	$25/$40/$75 Drug Copayment per Prescription
Out-of-Network	Not Covered

Additional Provisions

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

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

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

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

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

Provider-Administered Specialty Drugs - To receive benefits for Provider-administered Specialty Drugs, You must use a Preferred Pharmacy in Our Specialty Pharmacy Network.		
Cost share listed for Provider-administered Specialty Drugs is for the medication only. Providers may bill additional charges for the administering of the drug; refer elsewhere in the schedule for applicable benefit (e.g., chemotherapy, labwork). At the Specialty Pharmacy Network, You will pay the lesser of Your applicable Copayment or Coinsurance, the Maximum Allowable Charge, Our discounted rate or the Specialty Pharmacy Network's charge for the Prescription Drug.		
Provider-administered Specialty Drugs	**Preferred Specialty Pharmacy Network**	**Out-of-Network**
Provider-administered Specialty Drugs, as indicated in the Provider-administered Specialty Drug list	100%	60% of the Maximum Allowable Charge after Deductible

Lifetime Maximum	Unlimited	
Annual Deductible • Individual • Family	 $2,000 $4,000	 $4,000 $8,000
4th Quarter Deductible Carryover	Yes	
Annual Out-of-Pocket • Individual • Family	 $4,500 $9,000	 $9,000 $18,000

1. *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.*
2. *Prior Authorization required. Benefits may be reduced to 50% for Out-of-Network Providers and to 50% for Network Providers outside Tennessee (BlueCard PPO Providers) when Prior Authorization is not obtained. (See the Prior Authorization section for more information.) Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization. Inpatient hospital stays (except initial maternity admission) and Behavioral Health Services require a Prior Authorization.*
3. *Certain surgical procedures - hysterectomy, colonoscopy, tonsillectomy & adenoidectomy, esophagogastroduodenoscopy (egd.) - require Prior Authorization. Benefits may be reduced for Out-of-Network Providers and for Network Providers outside Tennessee (BlueCard PPO Providers) when Prior Authorization is not obtained. (See the Prior Authorization section for more information.) Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization.*
4. *CT scans, MRIs, nuclear medicine, and other similar technologies.*
5. *Includes physical, speech, occupational therapy, and acupuncture and cardiac and pulmonary rehabilitation.*
6. *Home health care may require Prior Authorization. Physical, speech or occupational therapy provided in the home do not require Prior Authorization and are subject to the therapy services visit limits.*
7. *All Transplant Services require Prior Authorization. Call customer service before any pre-transplant evaluation or other transplant service is performed to request Prior Authorization, and to determine if there are facilities available in the BDCT Network for Your specific transplant type. See the "Prior Authorization, Care Management, Medical Policy and Patient Safety" and "Organ Transplants – All Organ Transplants, Excluding Kidney" sections of this EOC for more information.*
8. *Network Providers not in our Transplant Network include Network Providers in Tennessee and BlueCard PPO Providers outside Tennessee.*